Physicians Mutual® Insurance for all of us.®

Physicians Life Insurance Company
Life Customer Service
PO Box 2018
Omaha, NE 68103-2018
1.800.228.9100

Life Claim Information

Insured's Information

Policy Number _____ – _____ – _____

Insured's Name _____
First MI Last

Address _____
Street

_____
City State Zip

Date of Birth ____ / ____ / ____ Date of Death ____ / ____ / ____
Month Day Year Month Day Year

Requestor's Information

Name _____
First MI Last

Address _____
Street

_____
City State Zip

Relationship to Insured _____ Phone Number ( ) _____

Email Address _____

Please provide

- A certified copy of the Death Certificate.
- The obituary notice.
- An assignment of benefits, if applicable.

Submit this form along with the documentation listed above to: Physicians Life Insurance Company, PO Box 2018, Omaha, NE 68103-2018. The Claims Department may require additional information for claim processing.

Benefits are subject to final approval. This policy may have exceptions and limitations, and we do not guarantee payment. Additional information may be required upon request.

Please contact us at 1-800-228-9100 during normal business hours if you have any questions or need additional assistance.

If you can assist us in contacting any beneficiary on this policy, please provide their information in the following section.

Beneficiary Information

Insured's Beneficiary _____
First MI Last

Address _____
Street

_____
City State Zip

Relationship to Insured _____ Phone Number ( ) _____

Insured's Beneficiary _____
First MI Last

Address _____
Street

_____
City State Zip

Relationship to Insured _____ Phone Number ( ) _____

Insured's Beneficiary _____
First MI Last

Address _____
Street

_____
City State Zip

Relationship to Insured _____ Phone Number ( ) _____