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Affidavit to Authorize Medico To Pay Policy Benefits

I, _____, state under oath that all information provided in this Affidavit is correct, and that the individuals identified below are the sole survivors and are related to the Deceased in the indicated relationships, that the Deceased died on the date specified leaving no estate to be probated, and the Deceased left no property, real or personal, requiring the administration of their Estate.

The purpose of this Affidavit is to authorize Medico Insurance Company, Medico Corp Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") to make payments of benefits under the Policy of Insurance identified below. All survivors have agreed that benefits shall be paid to the person(s) named below or their assigns. I hereby release and forever discharge the Company from any and all claims of whatsoever nature under the Policy of Insurance identified below. I further indemnify the Company for any and all liability for actions taken based upon the representations made in this Affidavit.

Name of Deceased: _____ Date of Death: _____

Policy Number(s): _____

Person(s) to whom benefits are to be paid: _____

Survivor's Name	Address, City, State, ZIP	Social Security #	Relationship to Deceased	Date of Birth

Signature _____ Date _____

State of _____ }
 County of _____ }

Subscribed and sworn to before me, a Notary Public, this _____ day of _____, 20_____.

Notary Public _____

**Medico Insurance Company administers for Ability Insurance Company
 Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company**