



AFFIDAVIT IN CASE OF LOSS OR DESTRUCTION OF DECEASED MEMBER'S CERTIFICATE

Instructions:

Please complete sections 1 thru 5.

You must personally sign this form in the presence of a Notary Public. Upon receipt of this properly completed Affidavit, the Death Claim will be processed accordingly.

If you have any questions, or for additional information, please contact us at ☎ 1-800-772-8632 or visit our website at www.prcua.org.

1. VENUE

STATE OF _____

COUNTY OF _____

} SS.

2. INSURED/ANNUITANT INFORMATION

CERTIFICATE \$ _____
FACE VALUE

FIRST (MI) LAST NAME

3. BENEFICIARY INFORMATION

_____, being first duly sworn on oath deposes and says that he/she reside at:

FIRST (MI) LAST NAME

STREET ADDRESS / CITY, STATE, ZIP CODE

_____ and is one of the beneficiaries of the deceased for the certificate noted in section 2 above.

PHONE NUMBER

BENEFICIARY FULL NAME/RELATIONSHIP/STREET ADDRESS, CITY, STATE, ZIP CODE

BENEFICIARY FULL NAME/RELATIONSHIP/STREET ADDRESS, CITY, STATE, ZIP CODE

BENEFICIARY FULL NAME/RELATIONSHIP/STREET ADDRESS, CITY, STATE, ZIP CODE

(continued on next page)

3. BENEFICIARY INFORMATION

(continued from page 1)

BENEFICIARY FULL NAME/RELATIONSHIP/STREET ADDRESS, CITY, STATE, ZIP CODE

BENEFICIARY FULL NAME/RELATIONSHIP/STREET ADDRESS, CITY, STATE, ZIP CODE

BENEFICIARY FULL NAME/RELATIONSHIP/STREET ADDRESS, CITY, STATE, ZIP CODE

This affiant further states that the insured is now deceased.

Further, this affiant states that he/she has made a diligent search but failed to locate the above-referenced certificate and so this affiant believes that said certificate has been lost or destroyed.

The affiant finally states that, to his/her knowledge, the insured made no change as to the beneficiary(ies) of said certificate after PRCUA issued it.

4. SIGNATURES

[Signature icon]

SIGNATURE OF BENEFICIARY

STATE COUNTY DATE - (MONTH/DAY/YEAR)

I, a Notary Public in and for the County in the State aforesaid, do hereby certify that on this date, the above person appeared before me and that they signed and delivered the aforesaid request for the uses and purposes therein set forth as their free and voluntary act.

SEAL:

[Signature icon]

SIGNATURE OF NOTARY PUBLIC

5. ADDITIONAL INFORMATION

Please mail all pages of this completed form to:

CLAIM DEPARTMENT
POLISH ROMAN CATHOLIC UNION OF AMERICA
984 N MILWAUKEE AVE
CHICAGO, IL 60642-4101

INTERNAL OFFICE USE ONLY

PROCESSED BY: (PLACE DEPARTMENT RECEIVED STAMP BELOW)

PERSONNEL

DATE