Claim For Life Benefit Payment

Financial American Life Insurance Company

P.O. Box 41255, Jacksonville, FL 32203

Phone: 1-844-882-1948 • FAX: 904-421-5920

IMPORTANT REMINDER – A Certified Copy of the Death Certificate, a copy of the Court Order Naming Executor and a copy of the Retail Installment Contract, should accompany this form. Failure to complete required sections and provide requested documentation will delay processing of your claim. You are responsible to continue making the required payments to the Creditor during the period your claim is pending.

SECTION A - TO BE COMPLETED BY THE CREDITOR (Please Print)

Name of Deceased_______________ Acct. No. _______________ Certificate No. _______________

Street Address _______________ City _______________ State ________ Zip ________

Initial Amount of Life Insurance $ _______________ (+)

Less Total Amount Paid on Account (as of date of death) $ _______________ (-)

Less Total Delinquency Charges and/or Other Charges (as of date of death) $ _______________ (-)

Balance Due Creditor (as of date of death) $ _______________

Date of Death_______________

Was the loan refinanced?

☐ Yes ☐ No

If Yes, When_______________

Creditor Name _______________ Telephone Number ( ) _______________

Street Address _______________ City _______________ State ________ Zip ________

I certify that the information given above is true and correct to the best of my knowledge and belief.

_______________ _______________ ______/______/______

Name/Title of Authorized Creditor Representative (Please Print) Signature of Authorized Creditor Representative Date

SECTION B - TO BE COMPLETED BY SURVIVING SPOUSE OR EXECUTOR (Please Print)

Name of Spouse or Executor (if any) _______________ Telephone Number ( ) _______________

Street Address _______________ City _______________ State ________ Zip ________

Provide complete names and addresses of all treating physicians, including family physician, hospital and pharmacies of the decedent **within the past five (5) years: (attach a separate sheet if necessary).**

	Name	Street	City	State	Zip	Phone #
Physician:						
Physician:						
Physician:						
Hospital:						
Hospital:						
Hospital:						
Pharmacy:						

X _______________ _____/_____/_____

Signature (Surviving Spouse or Executor) Date

Authorization to Obtain and Disclose Information

X____
Name of Deceased   Date of Birth

I authorize any employer, health care provider of any medical professional, hospital, pharmacy, or other medical care institution, the Veteran's Administration, the Medical Information Bureau, Inc., consumer reporting agency, government agency, insurance or reinsuring company, insurer, law enforcement agency, Social Security Administration, or other organization, or person having any records or information concerning this claim to provide such record or information to Financial American Life Insurance Company or any agent, attorney, consumer reporting agency, or independent administrator, acting on its behalf. With this authorization, Financial American Life Insurance Company may obtain and use health and medical information, including but not limited to information about use of drugs and/or alcohol, nicotine use, mental illness, physical diseases and illness. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I authorize Financial American Life Insurance Company personnel who obtain or who otherwise have authorized access to the information to release and disclose any such information to its reinsurers, the insured's Insurance agent or agents servicing the Policy or Policies and persons or organizations, including Financial American Life Insurance Company affiliated companies, providing to Financial American Life Insurance Company services related to claims administration including legal and investigative services. It may be redisclosed to persons or entities, that are not subject to privacy regulations, which means the Protected Health Information may no longer be protected.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the insurance company and may no longer be protected by federal law.

I understand that such information will be used by Financial American Life Insurance Company for the purpose of evaluating this claim for insurance benefits and that I or any authorized representative will receive a copy of this Authorization upon request. This authorization shall be valid from the date signed for the duration of the claim for benefits. I also understand that I may revoke this authorization at any time by requesting such of Financial American Life Insurance Company in writing. I have had full opportunity to read and consider the contents of this authorization. I certify that the statements contained herein are true and correct to the best of my knowledge and belief. Signature is required for benefit consideration.

X____
Signature (Surviving Spouse or Executor)   Date

WARNING - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.*

COLORADO ONLY – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties mat include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement.

DC ONLY- It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA ONLY – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY ONLY – Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW MEXICO ONLY – Any person who knowingly presents a false or fraudulent claim for payments of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OKLAHOMA ONLY – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

OHIO ONLY – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

TEXAS ONLY – Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinements in state prison.

VIRGINIA ONLY – * This notice is not applicable to life and health insurance.