DEATH CLAIM FORM

EACH BENEFICIARY MUST COMPLETE A SEPARATE CLAIM FORM

Merit Life® INSURANCE CO.
A Stock Company Domiciled in Indiana

BENEFICIARY INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Complete **SECTION 1**
2. Complete and sign **SECTION 2**
3. Read, sign and date **SECTION 3**
4. Print deceased's name and policy numbers in **SECTION 4**
5. Read, sign and date **SECTION 5**
6. Send **BOTH PAGES** of the completed, signed claim form and certified (original) Death Certificate or Coroner's Statement of Death to Merit Life Insurance Claims Department. Keep a copy for your records.

If you need assistance with completing this form, contact Merit Life Insurance Co. at 1-800-325-2147 ext 5113292.

SECTION 1 DECEASED INFORMATION (PLEASE PRINT)

DECEASED'S NAME	FIRST	MI	LAST
ALSO KNOWN AS	FIRST	MI	LAST
SOCIAL SECURITY #		DATE OF BIRTH	DATE OF DEATH
CAUSE OF DEATH:	ACCIDENT ☐ SUICIDE ☐	HOMICIDE ☐	NATURAL ☐
POLICY #(S)			
NAME OF DECEASED'S PRIMARY PHYSICIAN	FIRST	MI	LAST
MAILING ADDRESS			
CITY		STATE	ZIP
PHYSICIAN'S PHONE # ( )		PHYSICIAN'S FAX # ( )	
OTHER TREATING PHYSICIANS			

SECTION 2 BENEFICIARY INFORMATION (PLEASE PRINT)

FIRST		MI	LAST
MAILING ADDRESS			
CITY		STATE	ZIP
PHONE # ( )	DATE OF BIRTH	SOCIAL SECURITY #	

I AFFIRM THE INFORMATION I HAVE PROVIDED HEREIN IS ACCURATE AND COMPLETE.

BENEFICIARY SIGNATURE: _____ **DATE:** _____

BENEFICIARY'S RELATIONSHIP TO DECEASED: _____

SECTION 3 AUTHORIZATION TO RELEASE INFORMATION

By signing below, I authorize the release and disclosure of any of the deceased's information; including but not limited to: personal information, diagnosis(es), medical condition(s) and any reports that will aid the Insurance Company with its investigation of the payment of benefits. I authorize any physician, hospital, medical or medically related facility or any other individual or facility where the deceased had been treated, examined, admitted, or confined to release information concerning the deceased's medical history, mental or physical condition(s), or treatment which may be requested by the Insurance Company or its duly authorized representative for the purpose of determining eligibility or payment of benefits. I authorize any employer, insurer, or other individual or organization, including but not limited to: Social Security Administration or Railroad Retirement Board, having any records, files, reports, etc., concerning the deceased to release the information to the Insurance Company or its duly authorized representative for the purpose of determining eligibility or payment of benefits. This authorization shall remain valid for one year from the date I have signed below. However, I have the right to revoke this authorization in writing within one year from the date of my signature. A photocopy of this authorization shall be valid as the original and I or my authorized representative shall receive or keep a copy of this authorization.

BENEFICIARY SIGNATURE: _____ **DATE:** _____

SECTION 4 TO BE COMPLETED BY BENEFICIARY (PLEASE PRINT)

DECEASED'S NAME _____ **POLICY #'S** _____

SECTION 5 INSURANCE FRAUD WARNING

For your protection, where applicable, State law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud, files an application for insurance or statement of claim containing any materially false or fraudulent information, or knowingly conceals material information for the purpose of misleading, may be guilty of a crime and subject to denial of coverage, fines, confinement in prison and/or civil penalties.

CALIFORNIA

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

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 may 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA

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 AND PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and subjects such person to criminal and civil penalties.

I HAVE READ AND UNDERSTAND THE INFORMATION ON BOTH PAGES OF THIS FORM. I AFFIRM THE INFORMATION I PROVIDED HEREIN IS ACCURATE AND COMPLETE.

BENEFICIARY SIGNATURE: _____ **DATE:** _____

MAIL TO: **MERIT LIFE INSURANCE CO.**
601 N.W. SECOND STREET, P.O. BOX 39
EVANSVILLE, IN 47701-0039

OR FAX TO: **1-800-350-9582**

OR EMAIL TO: **InsClaims@onemainfinancial.com**