OneMain Solutions

Underwritten by:
American Health & Life Insurance Company
P.O. Box 2548, Fort Worth, Texas 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
InsClaims@onemainfinancial.com

Insured's Name: _____ Account/Policy # _____ Claim # _____
(if available)

Life Claim Form

Important Information

For Arizona residents only: "For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

For California residents only: "For your protection California law requires the following to appear on the form. 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 and confinement in prison."

For Pennsylvania residents only: "Any person who, with the intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that can include fines and confinement in prison."

For residents of other states (NOTE: None of these notices apply to Oregon residents.): 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."

INSTRUCTIONS

1. Send a copy of the certified Death Certificate.
2. Send all pages of the completed, signed claim form and any attachments to the Insurance Claims Department as shown above. Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal / medical information.

Note: Altered forms cannot be accepted.

Beneficiary Information - if there are 2 or more beneficiaries, attach a separate sheet of paper with the additional beneficiary information.

Name **Social Security #**

Complete mailing address **City** **State** **Zip**

Date of birth **Telephone #**

Signature of beneficiary or legal representative **Relationship to insured** **Date**

OneMain Solutions

Underwritten by:
American Health & Life Insurance Company
P.O. Box 2548, Fort Worth, Texas 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
InsClaims@onemainfinancial.com

Insured's Name: _____ Account/Policy # _____ Claim #_____
(if available)

Life Claim Form

Next-of-Kin Information

Name **Relationship to insured**

Complete mailing address **City** **State** **Zip**

Date of birth **Telephone #**

Deceased Information

Name **Name(s) deceased was also known as**

Date of birth **Date of death** **Social Security #**

If accidental death, date of accident **Telephone #**

Details of accident

Name of deceased's primary physician

Primary physician mailing address, telephone #

Other treating physician(s) name, address and telephone #

Other treating physician(s) name, address and telephone #

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 other individual or organization having any records, files, reports, etc., concerning the deceased to release the information to the Insurance Company or its duly authorized representative. 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 as valid as the original.

I affirm the information I have provided herein is accurate and complete. Signature below is the Claimant or legal representative.

Signature of legal representative **Relationship of insured** **Date**