OneMain Solutions®

Underwritten by:
SECURIAN LIFE INSURANCE COMPANY
Administered By:
American Health Life Insurance Company
P.O. Box 2548, Fort Worth, TX 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
insclaims@omf.com

Insured's Name: _____ Account/Policy # _____

Credit Life Claim Form

Claim # _____
(if available)

Important Information

" 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

SIGNATURE

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**

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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 #**

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 **Date**