

CREDIT LIFE CLAIM FORM



INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Complete **SECTION 1**
2. Print deceased's name and account number in **SECTION 2**
3. Read, sign and date **SECTION 3**
4. Return the completed and signed claim form and certified copy of the Death Certificate or Coroner's Statement of Death to Life Insurance Claims Department as indicated at the bottom of this form.
5. Keep a copy for your records.

Underwritten by:
American Health & Life Insurance Company
P.O. Box 2548, Fort Worth, Texas 76113-2548
T 800-307-0048 / Fax 817-348-7620

If you need assistance with this form, contact us at 1-800-307-0048, or the lender.

SECTION 1 DECEASED INSURED INFORMATION (PLEASE PRINT)

NAME	
ACCOUNT #	SCORE/BRANCH #
DATE OF LOAN	DATE OF DEATH

SECOND BENEFICIARY INFORMATION (PLEASE PRINT)

NAME	
MAILING ADDRESS	
CITY, STATE, ZIP	
DAYTIME PHONE #	SOCIAL SECURITY #
DATE OF BIRTH	RELATIONSHIP TO INSURED

W-9 Certification: The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholdings.

Under penalties of perjury, I certify that 1. The number shown on the form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and 2. I am not subject to backup withholding because (a) I am exempt from backup withholdings, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholdings, and 3. I am a U.S. person (including a U.S. resident alien).

CERTIFICATION INSTRUCTIONS: You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement account (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

IMPORTANT: Federal law requires that an insurance company send a 1099 form to all customers receiving over \$600 of total interest in a calendar year. For additional information regarding these interest payments, you should consult your tax advisor.

NEXT-OF-KIN AUTHORIZATION To be completed by the deceased's next-of-kin, if the insurance certificate contained a health question or statement. Give the name(s), complete address(es) and telephone numbers of any physician, hospital or other person who has attended the deceased insured and any pharmacy that filled a prescription for the deceased insured within the past 5 years.

NAME & SPECIALTY	FULL ADDRESS	TELEPHONE #

If the Deceased was known by any other name or alias, ie. maiden, hyphenated, nickname, list here:

NEXT OF KIN SIGNATURE: _____ **DATE:** _____



SECTION 2

CLAIMANT NAME _____ **ACCOUNT#** _____

SECTION 3 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.

INDIANA

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NEW JERSEY

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO

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 criminal penalties.

OHIO

Any person who, with intent to defraud or knowingly that he 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

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

NEXT OF KIN SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

MAIL TO: AMERICAN HEALTH & LIFE
INSURANCE COMPANY
P. O. BOX 2548
FORT WORTH, TX 76113-2548

OR FAX TO: 817-348-7620
OR EMAIL TO: Claims@onemainfinancial.com
OR SCAN TO INSURANCE

