American Health and Life Insurance Company or Merit Life Insurance Co.
Underwritten or Administered by: American Health and Life Insurance Company
Securian Life Insurance Company
Administered by: OneMain Assurance Services, LLC
P.O. Box 2548
Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9582 | insclaims@omf.com

Insured's Name: _____ **Claim Number:** _____

Account/Policy Number: _____

Claim Form for Reporting a Death - 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 this 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 New York residents only: "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 _____ **Date** (mm/dd/yy) _____

For Pennsylvania residents only: "Any person who, with 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, with 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 or any insurance representative doing so to a policyholder or claimant with regard to a settlement or award payable from proceeds may be reported to the department of regulatory agencies and may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that include fines and confinement in prison."

Usted puede obtener la versión en español de este formulario de reclamación en el sitio web de OneMain Solutions - www.onemainsolutions.com - Find a Form

American Health and Life Insurance Company or Merit Life Insurance Co.
Underwritten or Administered by: American Health and Life Insurance Company
Securian Life Insurance Company
Administered by: OneMain Assurance Services, LLC
P.O. Box 2548
Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9582 | insclaims@omf.com

Insured's Name: _____ **Claim Number:** _____

Account/Policy Number: _____

Claim Form for Reporting a Death - Instructions

1

- ❑ 1. Authorization Section should be signed and dated by Next of Kin (closest living relative).
- ❑ 2. Fully complete Beneficiary, Next of Kin, and Deceased Information Sections.
  - Beneficiary Section: For Credit Life Insurance, the first (1st) beneficiary is the creditor. Please complete the Beneficiary Section with second (2nd) beneficiary information.
    If there are 2 or more beneficiaries, attach a separate page with additional beneficiary information.
    If beneficiary is a minor, attach a copy of the minor's birth certificate, Social Security Card, and guardianship or custody papers.
  - Deceased Section: If Deceased was treated by additional physicians, attach a separate page with physician's name and contact information.
- ❑ 3. The person completing the claim form should sign and date the form.
- ❑ 4. Provide a copy of insured's death certificate and if available, an obituary.

2

- Depending on the Certificate of Insurance/Policy's requirements, additional claim information may be required.
- It is important to submit fully completed, signed, and dated claim form to avoid delays in processing this claim. Altered claim forms may not be accepted.
- Please be aware email is not considered a secure method of delivery for personal/medical information.

3

Please return your completed claim form and supporting documents to us in one of the following ways:

Email: insclaims@omf.com
Please be sure to include insured's name and account number/claim number in the subject line of your email.

Upload online:
www.OneMainSolutions.com/forms

Mail: OneMain Solutions
P.O. Box 2548
Fort Worth, TX 76113-2548

Fax: 800-350-9582

We are here to help!

Our Customer Solutions team is available to assist you
Monday through Friday, 8:00 am to 8:00 pm ET.

Toll free:
800-307-0048

Chat:
www.OneMainSolutions.com

Text:
60223

Usted puede obtener la versión en español de este formulario de reclamación en el sitio web de OneMain Solutions - www.onemainsolutions.com - Find a Form

American Health and Life Insurance Company or Merit Life Insurance Co.
Underwritten or Administered by: American Health and Life Insurance Company
Securian Life Insurance Company
Administered by: OneMain Assurance Services, LLC
P.O. Box 2548
Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9582 | insclaims@omf.com

Insured's Name: _____ **Claim Number: _____**

Account/Policy Number: _____

Claim Form for Reporting a Death
Authorization - To be completed by Next of Kin.
(Electronic signature not accepted)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, 45 CFR § 164.508, I hereby authorize any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Railroad Retirement Board, Veterans Administration or any other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to: American Health and Life Insurance Company for the administration of its policies or as the administrator for Merit Life Insurance Co. policies; or to OneMain Assurance Services, LLC as the administrator for Securian Life Insurance Company policies, for purposes of processing this claim.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness (except for psychotherapy notes which must be requested by separate authorization), alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment.

Initials _____

This authorization shall be valid for the duration of the claim. I have the right to revoke this authorization by providing a signed and dated, written notice to the insurance company above. Once this authorization is revoked, protected health information subject to this authorization will not be used or disclosed except to the extent that this authorization has already been relied upon. I understand that in executing this authorization the information disclosed may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance and Portability and Accountability Act (HIPAA). I understand that I have the right to retain a copy of this authorization and to inspect and receive any information disclosed under its terms. A photocopy of this authorization shall be considered as effective and valid as the original.

I affirm the information I have provided herein is accurate and complete.

Print name - Next of Kin	**Relationship to insured**
Signature - Next of Kin	**Date**

Usted puede obtener la versión en español de este formulario de reclamación en el sitio web de OneMain Solutions - www.onemainsolutions.com - Find a Form

American Health and Life Insurance Company or Merit Life Insurance Co.
Underwritten or Administered by: American Health and Life Insurance Company
Securian Life Insurance Company
Administered by: OneMain Assurance Services, LLC
P.O. Box 2548
Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9582 | insclaims@omf.com

Insured's Name: _____ **Claim Number:** _____

Account/Policy Number: _____

Claim Form for Reporting a Death			
Beneficiary Information Section			
Print Beneficiary's name	Social security number	Relationship to insured	
Beneficiary's mailing address	City	State	Zip
Beneficiary's date of birth (mm/dd/yy)	Telephone number		
Next of Kin Information Section			
Print Next of Kin's name	Relationship to insured		
Next of Kin's mailing address	City	State	Zip
Next of Kin's date of birth (mm/dd/yy)	Telephone number		
Deceased Information Section			
Print Deceased's name	Name(s) Deceased was also known as		
Deceased's date of birth (mm/dd/yy)	Social Security number		
Deceased's date of death (mm/dd/yy)	Date of accident, if applicable (mm/dd/yy)		
Details of accident, if applicable			
Name of Deceased's primary physician	Telephone number		
Mailing address	City	State	Zip
Other treating physician's name			
Mailing address	City	State	Zip
Name of hospital/medical facility utilized	Telephone number		
Mailing address	City	State	Zip
Printed name of person completing form		**Relationship to insured**	
Signature of person completing form		**Date** (mm/dd/yy)	

Usted puede obtener la versión en español de este formulario de reclamación en el sitio web de OneMain Solutions - www.onemainsolutions.com - Find a Form