

AMERICAN MODERN LIFE INSURANCE COMPANY

PO BOX 5323

CINCINNATI OH 45201-5323 TELEPHONE 1-888-672-6820, ext 2110

CREDIT LIFE INSURANCE - DEATH CLAIM FORM

- Instructions:**
- (1) **Part 1** is to be completed by the **Financial Institution (Creditor)**.
 - (2) **Part 2** is to be completed by the **Representative of the Estate**.
 - (3) **Return the form, completed in its entirety, to the address above.**
 - (4) **ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE.**

PART 1: CREDITOR: Financial Institution of the Loan: Complete This Section.

Customer Name:	Certificate Number:	Loan Number:	Effective Date:	Loan APR:	Term of Insurance:

- (1) Attach each of the following to this form: a copy of the Application for Insurance; a copy of the Certificate of Insurance; a copy of the Truth in Lending Disclosure for this loan; a copy of this loan's history for the one-year period prior to and up to the date of death; and the interest per diem on this loan as of the date of death.
- (2) Please reference the Application for Insurance and/or the Certificate of Insurance. **Determine which type of credit life insurance was purchased for this loan (Net, Gross, OR Revolving Open-End).** Then, please complete the corresponding section below.

NET PAYOFF:

Original amount of insurance: \$ _____
 Interest Per Diem at date of death: \$ _____
 Total \$ Amount of Payments Made _____
After Date of Death: \$ _____

REVOLVING OPEN-END:

Outstanding Balance Due at Date of Death: \$ _____
(Include Principal and Earned Interest)

- (1) **Unpaid Balance at Date of Death:** \$ _____
-PLUS-
- (2) **Earned Interest at Date of Death: (+)** \$ _____
-EQUALS-
- (3) **Amount Due to First Beneficiary: (=)** \$ _____

GROSS PAYOFF:

- (1) Original amount of insurance: \$ _____
- (2) Amount of decrease in coverage *(please complete the following formulas):*
 - (a) $\frac{\$ \text{_____}}{\text{(Original amount of insurance)}} \div \frac{\text{_____}}{\text{(Term of Insurance)}} = \$ \frac{\text{_____}}{\text{(Monthly Benefit)}}$;
 - (b) $\frac{\$ \text{_____}}{\text{(Monthly Benefit)}} \times \frac{\text{_____}}{\text{(# of months insurance was in effect at Date of Death)}} = (-) \$ \frac{\text{_____}}{\text{(Amount of Decrease)}}$
- (3) Amount of Insurance Coverage at Date of Death *(Line 1 Minus Amount of Decrease):* \$ _____
- (4) Amount of Insurance Payable to Creditor: \$ _____
- (5) Balance Payable to Second Beneficiary (Estate): \$ _____

CREDITOR NAME: _____
STREET: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

*(*Please list the address to which potential credit insurance benefits should be mailed.)*

I represent the above referenced creditor, and hereby certify that the above information is complete and true.

YOUR SIGNATURE: _____ **DATE:** _____
Print Your Name: _____ **Title:** _____ **Telephone:** _____

(Over) →

PART 2: Estate Representative: Executor of Estate or Next of Kin: Complete This Section.

(1) **ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE TO THIS CLAIM FORM. We are unable to consider the claim without this necessary certified documentation.**

(2) Please list the name, address, Social Security number, and date of birth of the deceased.

Name: _____

Address: _____

Date of Birth: _____ **Social Security Number:** _____

(3) List all physicians who attended to the deceased within the last 5 years, including **family physician**. Please attach additional sheets, if necessary.

Name of Physician/Hospital:	Treated Deceased For (Medical Condition):	Full Address, Including Zip Code:	Telephone Number, Including Area Code:	Dates Deceased Treated With This Medical Care Provider:

(4) List all pharmacies that provided prescription medication(s) to the deceased within the past 5 years.

Name of Pharmacy:	Full Mailing Address and Phone Number:	Name of Prescription/Medication(s) Provided:

(5) Have the courts appointed an Executor/Executrix for the Estate of the deceased? Yes No
If YES, please attach copies of this legal documentation. This will assist in the processing of the claim.

(6) Please sign and date the authorization below.

I hereby consent and request that employees or representatives of American Modern Life Insurance Company be permitted to examine and obtain copies of all hospital, medical, and pharmaceutical records of every sort and kind, interview and obtain written reports from doctors, pharmacies, and other attendants regarding all matters relating to examination, diagnosis, care and treatment of the deceased. I further understand that the information requested may contain information regarding HIV testing and/or treatment for AIDS, AIDS Related conditions, drug or alcohol abuse, and/or psychiatric conditions.

A photocopy of this authorization shall be accepted with the same authority as the original.

Signature: _____ Date: _____

Please Print Above Estate Representative's Name: _____

Relationship to the Deceased: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: () _____

NOTICE: *Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud*