FINANCIAL AMERICAN LIFE INSURANCE COMPANY

Administrative Offices:

Summit Administrators, Inc.

110 West Rosamond
Houston, TX 77076-3919

Toll-Free 1.800.275.3414 • FAX 713.694.0298

DEATH CLAIM FORM

PLEASE HAVE THE DECEASED INSURED'S NEXT-OF-KIN COMPLETE AND SIGN THE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

INSURED'S NAME:	
SOCIAL SECURITY NO.	CERTIFICATE NO.

CREDITOR INFORMATION:

NAME OF CREDITOR:			
ADDRESS:	CITY	STATE	ZIP
SECOND BENEFICIARY:		RELATIONSHIP	
DATE OF DEATH	FIRST PAYMENT DUE DATE		

CALCULATIONS:

1. ORIGINAL AMOUNT OF INSURED'S INDEBTEDNESS	$
2. GROSS AMOUNT PAID OR CREDITED THEREON	$
3. GROSS UNPAID BALANCE AT DEATH	$
4. UNEARNED INTEREST PAID OR CREDITED	$
5. NET UNPAID BALANCE DUE CREDITOR	$
6. AMOUNT OF INSURANCE, IF ANY, TO SECONDARY BENEFICIARY	$

I HEREBY CERTIFY THAT THE INFORMATION SHOWN ABOVE IS TRUE AND CORRECT WITH RESPECT TO THE BENEFITS BEING CLAIMED HEREUNDER, AND I FURTHER CERTIFY THAT ATTACHED DEATH CERTIFICATE IDENTIFIES THIS INSURED BORROWER.

______________________________ DATE

______________________________ CREDITOR REPRESENTATIVE SIGNATURE

PLEASE ATTACH:

1. **COPY OF DEATH CERTIFICATE**
2. **COPY OF THE NOTE / INSTALLMENT CONTRACT**
3. **COPY OF CERTIFICATE OF INSURANCE**

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Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following information to Financial American Life Insurance Company

INSURED INFORMATION			
NAME	SOCIAL SECURITY NUMBER - -	BIRTH DATE / /	DAYTIME TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE

MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION:			
NAME			TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME			TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE

DESCRIPTION OF INFORMATION TO BE RELEASED	
ENTIRE MEDICAL RECORD ☐ YES ☐ NO	HIV / AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT ☐ YES ☐ NO
OTHER	

I UNDERSTAND THAT:

a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization
b. This Authorization will expire on the following date ____.
c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.
d. This authorization is voluntary and I have the right to refuse to sign it.
e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.
f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.
h. I agree that a photocopy of this authorization shall be as valid as the original.
i. I, or my authorized representative, have the right to receive a copy of this authorization.

YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE)	DATE
X	/ /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MY BE REQUIRED)