

**American Underwriters Life Insurance Company**  
Phoenix, Arizona

**Great Fidelity Life Insurance Company**  
Indianapolis, Indiana

**Century Life Assurance Company**  
Oklahoma City, Oklahoma

**United Fidelity Life Insurance Company**  
Dallas, Texas

Administrators: Inter-Américas Insurance Corporation, Inc.  
P.O. Box 9510, Wichita, Kansas 67277  
Phone: (316) 794-2200 Fax: (316) 794-8470 Email: iai@iai-online.com

**CLAIMANT'S STATEMENT FOR DEATH CLAIM**

**To Be Completed by the Creditor**

Name of Debtor \_\_\_\_\_ Certificate or Policy # \_\_\_\_\_  
Original Loan Date \_\_\_\_\_ Original Amount of Insurance \$ \_\_\_\_\_  
Original Monthly Payment \_\_\_\_\_ Term of Loan in Months \_\_\_\_\_  
**For Monthly Outstanding Balance and CAP Accounts – Send Loan History for the six months preceding the date of claim.**  
Current Mo. Pmt. \$ \_\_\_\_\_ Loan Balance on date of death \$ \_\_\_\_\_ Current Int. Rate % \_\_\_\_\_  
Creditor \_\_\_\_\_ Member's account # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date Signed \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Phone ( ) \_\_\_\_\_


**To Be Completed by the Next of Kin**

1. Deceased's name in full \_\_\_\_\_ SS # \_\_\_\_\_  
a. Residence \_\_\_\_\_  
b. Occupation \_\_\_\_\_ Date Last Worked \_\_\_\_\_  
c. Name of Spouse \_\_\_\_\_ SS # \_\_\_\_\_  
2. Date of Birth \_\_\_\_\_ City & State of Birth \_\_\_\_\_ Source \_\_\_\_\_  
3. Date of Death \_\_\_\_\_ Place of Death (address) \_\_\_\_\_  
a. Cause of Death \_\_\_\_\_  
b. If death was due to accident, suicide, or homicide, please specify which.  Accident  Suicide  Homicide  
4. List the Names and addresses of all physicians who attended the deceased and hospitals or institutions where (s)he was treated during the last illness and during five years prior thereto.  
Name Address Date Disease or Condition  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. State your relationship to the deceased \_\_\_\_\_  
The undersigned hereby makes claim for insurance proceeds. (Please sign the medical release on the reverse side of this form.)

**WARNING:** For your protection, some states, including California, require the following to appear on this form:  
**Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime and subject to a fine and/or confinement.**

I hereby authorize the above named creditor to release any and all information relating to the insured loan for the purpose of this death claim.

 Signature of Next of Kin or Beneficiary \_\_\_\_\_ Date \_\_\_\_\_  
Address (street, city, state, zip) \_\_\_\_\_  
Social Security or Estate Tax ID Number \_\_\_\_\_

**INSTRUCTIONS FOR COMPLETING PROOFS OF DEATH**

Proofs of Death ordinarily consist of:  
1. Claimant's Statement  
2. **CERTIFIED** Copy of death certificate, and  
**(We will not accept photocopies)**  
3. Policy or certificate.  
(Additional Instructions on page 2.)

**LOST POLICY RELEASE**  
I certify that policy/certificate # \_\_\_\_\_ has been lost, destroyed, or cannot otherwise be produced.  
\_\_\_\_\_  
Claimant Date

We may require other information in certain circumstances. Some of these other requirements are given below:

1. If the primary or first beneficiary is deceased, we will need evidence of death.
2. If there is more than one beneficiary, only one need sign this form, but the names and addresses of other beneficiaries should be given on a separate sheet.
3. If an estate, executor or administrator is a beneficiary, a certificate of the appointment and qualification of the executor or administrator by court proceedings must be submitted to us.
4. If a minor is a beneficiary and no trustee has been named to receive his share, a guardian must be appointed by court proceedings and a certificate of the appointment and qualification of such person must be submitted to us. If no guardian is appointed, the funds will be held at simple interest until the minor becomes of age and requests payment.
5. If proceeds of the policy have been assigned as collateral security for a loan, the assignee should furnish a written statement of the amount due and the beneficiary should verify the correctness of the amount.
6. If the proceeds are payable to a group, such as "Children," a sworn statement should be submitted to us giving the names and dates of birth of each. If any have died, a death certificate for each deceased child must be submitted.
7. If a claim is made for accidental death benefits, consideration of the claim can be facilitated by furnishing a police report, or coroner's verdict, in addition to the proofs of death.

## AUTHORIZATION FOR RELEASE OF INFORMATION

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## HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

\_\_\_\_\_  
Name of deceased

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to the above name deceased person ("The Health Care Provider") to disclose the entire medical record, prescription history, medications prescribed and any other protected health information concerning the deceased to the insurance company named above, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict the protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so the insurance company may evaluate my claim for the proceeds of the insurance policy on the deceased.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the insurance company at the administrative office address above. I understand that a revocation is not effective to the extent that any of The Health Care Providers has already relied on this authorization to disclose information about the deceased or to the extent that the insurance company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the insurance company except: 1) as authorized by me; 2) as required by law; or 3) to other persons or businesses with whom the insurance company has a business relationship. Such a relationship must require the receipt of this medical information in order to perform their business with the company.

I understand that The Health Care Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release the deceased's complete medical record, the insurance company may not be able to process my claim for benefits. I understand that any authorized representative or I will receive a copy of this authorization upon request.

\_\_\_\_\_  
Signature of next of kin or beneficiary (or representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of representative's authority or relationship