



Certificate Number: _____

CREDIT LIFE CLAIM FORM

Instructions: PLEASE ATTACH

(1) A certified copy of death certificate.

NOTE: This is the copy containing the certifier's original signature and/or embossed seal.

(2) If available, please provide copies of proof of executor or personal representative papers.

IMPORTANT INFORMATION:

- PLEASE SUBMIT ORIGINAL FORM (NO PHOTOCOPIES), FULLY COMPLETED.
- CLAIM PAYMENTS ARE MADE DIRECTLY TO THE LENDING INSTITUTION.
- PLEASE REMEMBER YOU ARE UNDER SEPARATE CONTRACT WITH YOUR LENDER. THE ESTATE MAY STILL BE RESPONSIBLE FOR MAKING CERTAIN THE LOAN REMAINS CURRENT UNTIL BENEFITS ARE APPROVED.
- THE CERTIFICATE DOES NOT COVER LATE FEES OR EXTENSIONS CHARGED BY YOUR CREDITOR.

Part 1 – To Be Completed By Creditor

- Name & Address of Insured: _____
- Date of Death ____/____/____
- Monthly Payment Amount: \$ _____
- Effective Date of Loan: ____/____/____
- Term of Loan: _____
- Account Number: _____
- Original Amount of Note or Finance Contract \$ _____
- Total Amount Paid to Date of Death \$ _____
- Net Balance Due at Date of Death \$ _____
- Total Number of Extensions: _____
- Amount of Late Fees as of Date of Death \$ _____
- Amount of Daily Per Diem \$ _____

Creditor's Name _____ Creditor's Address _____

Creditor's Signature _____ Title _____ Phone Number _____ Date ____/____/____

Name, Address & Phone Number of Creditor _____

By: _____
(Lending Representative)

Please include a copy of the loan contract and/or lease agreement and payment history

TO BE COMPLETED BY SURVIVING SPOUSE/EXECUTOR:

Insurance Certificate Number: _____ Effective Date: _____

SPECIAL NOTICE-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 OHIO ONLY-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 a false or deceptive statement is guilty of insurance fraud.

If the death occurred during the first two policy years, have the Authorized Representative or Next of Kin sign the Authorization and provide the information on the reverse side of this form. (If available, please provide copies of proof of executorship or personal representative.)

(Continued on Back)



Certificate No.: _____

**Additional Death Claim Information
To Be Completed by Authorized Representative or Next of Kin**

AUTHORIZATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, including Social Security Administration and State Unemployment Office, insurance company, group policyholder, consumer reporting agency, employer or benefit plan administrator to provide North American Insurance Company or an agent, attorney, consumer reporting agency, or independent administrator, acting on its behalf any and all medical and non-medical information including but not limited to information concerning advice, diagnosis, care or treatment provided that patient or employee or deceased named below, including information relating to mental illness, use of drugs, use of alcohol, Acquired Immune Deficiency Syndrome (AIDS), or an AIDS related complex (ARC). I also authorize the employer, group policyholder or group plan administrator, to provide North American Insurance Company with financial or employment-related information.

I also authorize the creditor or any transferee of the indebtedness to provide North American Insurance Company with copies of the credit application and any other information regarding the credit transaction, which is the basis of the insurance.

You may refuse authorization to disclose all or some health care information. You may also revoke the authorization in writing at any time subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation. However, such refusal or revocation may result in denial of claim or other adverse effects.

I understand that such information will be used by North American Insurance Company for the purpose of evaluating this claim for life benefits and that I or any authorized representative will receive a copy of this authorization upon request.

Furthermore, by signing below, I certify that this information is true, correct, and complete to the best of my knowledge and belief.

This authorization is valid for 24 months from the date signed.

_____	_____
Name of Deceased	Please List Any Other Names Deceased May Have Used
_____	_____ / _____ / _____
Signature of Authorized Representative or Next of Kin	Date Signed
_____	_____
Printed Name of the Authorized Representative or Next of Kin	Phone Number

Mailing Address of the Authorized Representative or Next of Kin	

1) Please provide cause of death and date of death: _____

2) Please provide the name, address and phone number of the deceased's family physician: _____

List all other physicians, chiropractors, psychologists, or hospitals that have treated the deceased during the five years prior to the date this insurance was purchased, regardless of the condition. (Include up to date of death.) If none, state NONE. If not enough space provided, please attach a separate sheet.

Name of Medical Provider	Complete address & phone number	Period Treated From / To	Reason for Treatment
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- a. _____
- b. _____
- c. _____
- d. _____