



**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 Oxford Life 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 Oxford Life Insurance Company with financial or employment-related information.

I also authorize the creditor or any transferee of the indebtedness to provide Oxford Life 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 affects.

I understand that such information will be used by Oxford Life 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
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____
e. _____	_____	_____	_____
f. _____	_____	_____	_____