CREDIT LIFE INSURANCE CLAIM

PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM

Credit Insurance Processing Center
100 West Bay Street • PO Box 44130
Jacksonville, FL 32231-4130
1-800-888-2738, Ext. 8391

- ❑ Life of the South Insurance Company
- ❑ Classic Life Assurance Company
- ❑ Southern Financial Life Insurance Company
- ❑ Protective Life Insurance Company
- ❑ Triangle Life Insurance Company
- ❑ ________________________________

This form must be completed in full and FAXED to (904) 359-2041 with the following:

1. A certified copy of the death certificate (front and back, if applicable).
2. A copy of the disclosure statement on the loan.
3. A copy of the signed insurance certificate, including the health statement, if separate.

The Authorization statement must be completed before this claim can be evaluated.
If death occurred within 24 months of the effective date of insurance coverage, the legal next of kin or estate representative **MUST** complete the Medical History Statement on the reverse side of this form and include a copy of the court's appointment of estate representative.

THIS CLAIM CANNOT BE EVALUATED WITHOUT ALL THE REQUIRED MEDICAL INFORMATION AND DOCUMENTS

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. See attached for State Specific Fraud Warnings.

CREDITOR'S STATEMENT

I. CLAIMANT'S INFORMATION:

Full Name of Claimant:		Social Security #
Date of Death:	Cause of Death:	

II. COVERAGE INFORMATION:

Insurance Certificate Number		Effective Date	Term	Premium
Plan Type ❑ Single Premium ❑ Monthly Outstanding Balance		Number of Lives Insured ❑ Single ❑ Joint	If joint, name of Joint Insured	
Coverage Type	❑ Credit Card	❑ Checking Overdraft	❑ Home Equity	❑ N/A
Name of Second Beneficiary, if any				
Street Address		City	State	Zip

III. LOAN INFORMATION:

Loan Number	Original Amt. of Insurance $	Amt. Paid on Account $
Gross Balance on Date of Death $	Net Payoff on Date of Death (Int. per day: ______ %) $	
Was this a variable interest loan? ❑ Yes ❑ No	If Yes, give Original rate: __________ % and highest rate: _______ %	
Was this loan a renewal? ❑ Yes ❑ No	If Yes, give original loan date	
If renewal, has coverage been continuous with our company? ❑ Yes ❑ No	If Home Equity, have there been any advances in the 6 months immediately proceeding death? ❑ Yes ❑ No	

NOTE: If **renewal,** copies of the original notes **MUST** accompany this claim form.
If **Home Equity**, a copy of the history card or payment history **MUST** accompany this claim form.

IV. CREDITOR/MASTER POLICYHOLDER INFORMATION:

Name of Creditor		Email Address	
Street Address	City	State	Zip
Signature of Creditor Representative	Date	Telephone	
Name of Master Policyholder (if different from Creditor)		Master Policy Account Number	

Name of Deceased Claimant	Email Address
Print Name of Legal Next of Kin or Estate Representative	Signature of Legal Next of Kin or Estate Representative
Address	Date Signed (Mo/Day/Yr)

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to: ______________________________

Insurance Company and their Authorized Administrator

The purpose of this disclosure is to evaluate the application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody and control pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of their physical or mental condition are to be released. Such records and information to be released may include but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescription, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, record custodians, or anyone else to release any and all records and information regarding:

Patient's Name: ______________________________

Other Names Used: ______________________________

Date of Birth: ______ /______ /______ Social Security Number: ______________________________

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company or their authorized administrator and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of (12) twelve months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of the insurance company or their authorized administrator in writing to: P.O. Box 44130, Jacksonville, Florida 32231-4130, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

Date: ____ /____ /____ **Signature of Patient/Guardian/Personal Representative**: ______________________________

Legal relationship to applicant: ______________________________ (Only if signed above by guardian or personal representative).

MEDICAL HISTORY STATEMENT:

(Complete only if death occurred within 24 months of the effective date of insurance coverage).

1. When did symptoms of last illness appear? ______________________________
2. When did deceased first consult physician for last illness? ______________________________
3. Physicians or practioners who treated the deceased during the period beginning 24 months prior to insurance coverage through the date of death:

Name	Address	Date of Visit	Reason for Visit

4. Hospitals, clinic or other medical care facilities in which the deceased has been treated during the period beginning 24 months prior to insurance coverage through the date of death:

Name	Address	Date of Treatment or Confinement

ATTENDING PHYSICIAN'S STATEMENT:

(Complete only if unable to obtain a copy of the death certificate).

Deceased's Full Name			Date of Birth
Cause of Death			Date of Death
Was death due to: ❑ Suicide ❑ Homicide ❑ Accident ❑ Undetermined ❑ Natural Causes			
When were you first consulted for this condition?		How long had the deceased had this condition?	
What other conditions contributed to death?		Was an autopsy done or other official inquiry made? ❑ Yes ❑ No	
Print Name of Attending Physician	Signature of Attending Physician	Date	Telephone
Street Address		City	State / Zip

STATE SPECIFIC FRAUD WARNINGS

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas and New Mexico Residents: 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 civil fines and criminal penalties.
California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware and Idaho Residents: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of a claim containing any false, incomplete, or misleading information is guilty of a felony.
District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Louisiana and Maryland Residents: Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Tennessee and Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.
Maine Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Minnesota Residents: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire Residents: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. §638:20.
New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.
Ohio Residents: 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.
Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact may be guilty of an insurance fraud, which is a crime, and may be subject to prosecution.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Texas and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

DETACH HERE AND GIVE THIS SIDE TO THE CUSTOMER