



Allstate

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Credit Claims Department

1776 American Heritage Life Drive / Jacksonville, Florida 32224

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our customer service department at 1-800-858-4570

DEATH CLAIM FORM CREDIT LIFE INSURANCE

PLEASE PRINT OR TYPE

-TO BE COMPLETED BY CLAIMING CREDITOR-

1. NAME OF DECEASED INSURED: _____ DATE OF DEATH _____
First Middle Last Mo./Day/Yr.
2. ISSUING PRODUCER: _____
Name Address City/State/Zip Code Agent Code/Reporting #
3. CLAIMING CREDITOR _____ ()
(Creditor Beneficiary) Name Address City/State/Zip Code Phone #
4. SECOND BENEFICIARY, (as shown on certificate) _____
(If none, Estate) Name Address City/State/Zip
5. NET PAYOFF (Loan Balance minus unearned interest as of Date of Death) \$ _____
6. WAS DECEASED RECEIVING DISABILITY BENEFITS AT TIME OF DEATH? YES NO
7. REMARKS/COMMENTS _____

8. TO AVOID DELAY IN PROCESSING, PLEASE ATTACH:
 (CHECK IF ATTACHED)
 COPY OF CERTIFICATE/POLICY
 CERTIFIED COPY OF DEATH/CORONER'S CERTIFICATE
 COPY OF HEALTH APPLICATION
 COPY OF LOAN CONTRACT
 LOAN/ACCOUNT NUMBER _____

NOTE: A copy of the note and security Agreement or retail installment contract or ledger card often speeds claim handling, if available.

9. CERTIFIED AS COMPLETE AND CORRECT:
 BY: _____ DATE _____
AUTHORIZED REPRESENTATIVE OF CLAIMING CREDITOR

Name/Address of all physicians who treated the deceased during the past five years

PHYSICIAN OR HOSPITAL	ADDRESS/PHONE	DATE OF TREATMENT	DISEASE OR CONDITION
Additional space is provided on back of form			

AUTHORIZATION: I hereby authorize any hospital, practitioner, clinic, or other medically related facility, pharmacy, insurance company or government agency or other person who has attended the deceased to disclose or furnish American Heritage Life Insurance Company, or its designee, any and all medical information with respect to any illness or injury the Insured may have suffered including but not limited to medical history, drug/alcohol abuse, AIDS or AIDS related conditions; or other consultations, prescriptions, diagnosis and treatment; or any information regarding benefits provided, together with copies of all other medical records that may be requested. The information provided to American Heritage Life Insurance Company, or its designee is to be used solely for purposes of evaluating a claim. This Authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this Authorization by notifying American Heritage Life in writing of my desire to do so. A photographic copy of the Authorization shall be as valid as the original, regardless of the date signed. I understand that I or my representative may receive a copy of this Authorization by supplying policy/certificate number (s) and Insured's name in a written request to the company or its designee.

DATE

CLAIMANT'S SIGNATURE

RELATIONSHIP TO THE INSURED (DECEASED)

CLAIMANT'S MAILING ADDRESS

CITY, STATE AND ZIP CODE

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FOR YOUR PROTECTION, PLEASE READ NOTICES ON REVERSE SIDE

PLEASE READ THE FOLLOWING NOTICES AS APPLICABLE TO YOUR STATE

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA:

Any 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.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a 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.

NOTICE IN ARIZONA: 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.

NOTICE IN COLORADO: 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.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN OHIO: 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.

NOTICE IN PENNSYLVANIA: 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.

NOTICE IN DISTRICT OF COLUMBIA: 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.

NOTICE IN TENNESSEE: 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 and denial of insurance benefits.

(Continued from front) Name/Address of all physicians who treated the deceased during the past five years

PHYSICIAN OR HOSPITAL	ADDRESS/PHONE	DATE OF TREATMENT	DISEASE OR CONDITION