LIFE ASSURANCE COMPANY
P.O. BOX 14998
Oklahoma City, OK 73113
1-800-522-1314

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.***

APPLICATION FOR CREDIT LIFE DEATH BENEFITS

CLAIM FORM MUST BE ACCOMPANIED BY:

A CERTIFIED COPY OF THE DEATH CERTIFICATE

ALL BENEFICARIES NAMES, MAILING ADDRESS, AND SOCIAL SECURITY NUMBERS

CREDITOR'S STATEMENT

NAME OF INSURED ______________________________ POLICY # ______________

POLICY EFFECTIVE DATE ________________________ POLICY WAS PURCHASED AT ______________________________

NAME OF CREDITOR (Where payments are due) ____

ADDRESS OF CREDITOR ______________ CITY OR TOWN ______________ STATE ______ ZIP CODE ______ PHONE # ______

NET AMOUNT DUE CREDITOR BENEFICIARY AT DATE OF DEATH $ ________________ GOOD THROUGH ______________
(TO BE PROVIDED BY CREDITOR)

I HEREBY CERTIFY THE AMOUNT DUE CREDITOR BENEFICIARY SHOWN ABOVE DOES NOT EXCEED THE LOAN BALANCE.

SIGNED ____ DATE ______________

AUTHORIZATIONS FOR NEXT OF KIN

AUTHORIZATION MUST BE COMPLETED IN FULL TO AVOID DELAY IN PROCESSING

NAMES AND ADDRESSES OF ALL HOSPITALS, PHYSICIANS OR PRACTITIONERS WHO ATTENDED OR PRESCRIBED FOR THE DECEASED WITHIN THE LAST THREE YEARS.

NAME	ADDRESS	DATE OF ATTENDANCE	DISEASE OR CONDITION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I, the undersigned, do hereby authorize any provider of health care who has administered or provided the (Deceased Insured)______________________________, with medical services including, but not limited to any physician, medical practitioner, psychologist, chiropractor, hospital, including the Veterans Administration hospital, clinic or other health care facility to provide any and all information relative to the medical history and condition of the deceased to Life Assurance Company or its representative. I hereby authorize any medical provider to submit any and all information in regard to physical and mental health including history, all consultations, diagnosis, prescriptions, treatments, tests, including information regarding alcohol or drug abuse. Such information may indicate a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

A photocopy of this authorization shall be valid as if it were an original document. This authorization shall continue and be valid as long as there is a claim with Life Assurance Co. pursuant to an insurance policy.

By executing this document, I hereby certify that I have read and understand this authorization and do so as a free and voluntary act.

I (We) hereby certify that the answers on this claim form are true, accurate and correct.

SIGNATURE OF NEXT OF KIN ______________ RELATIONSHIP ______________ DATE SIGNED ______________

ADDRESS ______________ CITY OR TOWN ______________ STATE ______ ZIP CODE ______ PHONE # ______

THE FURNISHING OF THIS FORM DOES NOT CONSTITUTE ADMISSION OF LIABILITY ON THE PART OF THE COMPANY.

MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize any provider of health care who has administered or provided (Deceased Insured's name) ____, with medical services including but not limited to any licensed physician, medical practitioner, pharmacy benefits manager, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of the deceased health, to give the Life Assurance Company, Inc. any such information. A photographic copy of this authorization shall be as valid as the original. This authorization will be valid as long as there is a claim with Life Assurance Company pursuant to an insurance policy, but I understand that I may revoke it at any time by giving written notice to the Company at P.O. Box 20667, Oklahoma City, OK 73156. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. I also understand that my revocation of this authorization will not result in the deletion of any information that may have been released to Life Assurance Company while this authorization is in force. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without any further written authorization and may no longer be protected. **Notice: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/Aids (Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which the deceased may have been treated while a patient here.**

By executing this document, I hereby certify that I have read and understand this authorization and do so as a free and voluntary act.

I hereby certify that the answers on this claim form are true, accurate and correct.

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 FELON.

X____ ____

Signature of Nest of Kin | Relationship | Date

____ ____

Address | City or Town | State | Zip | Phone #