LAC
Life Assurance Company

LIFE ASSURANCE COMPANY, INC.
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 (See Reverse For Disability Claim Form)

Claim Form MUST Be Accompanied By:

1. A certified copy of the death certificate.
2. A copy of the policy.
3. A copy of the loan contract.

CREDITOR'S STATEMENT

Name of Insured _____ Acct. # _____ Policy # _____

Policy Effective Date _____ Policy Was Purchased at _____

Name of Creditor (Where payment 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.