CREDIT LIFE AND/OR ACCIDENTAL DEATH CLAIM
PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM

Claims Service Center
P.O. Box 45153, Jacksonville, FL 32232-5153
1.800.888.2738, Ext. 8390
Fax: 1.904.355.5878
Email: claims@fortegra.com

CREDIT INSURANCE COMPANY

- ☐ Life of the South Insurance Company
- ☐ Bankers Life of Louisiana Insurance Company
- ☐ American Republic Insurance Company
- ☐ Southern Financial Insurance Company
- ☐ _____

This form must be completed in full with the following:

1. A certified copy of the Death Certificate (front and back, if applicable). If unable to obtain a copy of the Death Certificate, the Attending Physician's Statement on the reverse side of this form must be completed.
2. A copy of the Disclosure Statement on the loan.
3. A copy of the Insurance Certificate, as well as the Health Statement, if separate.
4. If Accident occurred while riding in, or was due to a motor vehicle, please attach a copy of the police report.

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

CREDITOR'S STATEMENT

I. COVERAGE INFORMATION:

Full Name of Claimant			Social Security Number
Date of Death	Cause of Death		
Insurance Certificate Number	Effective Date	Term	Premium
Coverage Type ☐ Level ☐ Net Pay ☐ Gross Decreasing	Number of Lives Insured ☐ Single ☐ Joint	If Joint, name of Joint Insured	
Name of Second Beneficiary, as shown on Certificate		Second Beneficiary Telephone Number	
Second Beneficiary Address	City	State	Zip

II. LOAN INFORMATION:

Loan Number	Original Amount of Insurance $	Amount Paid on Account $
Payoff: Amount necessary to discharge indebtedness after crediting applicable refunds figured as of Date of Death $		
Payoff Good until Date	Daily Interest: _____ %	
Was this loan a renewal? If yes, give original loan date ☐ Yes ☐ No _____ / _____ / _____	Has coverage been continuous with our company? ☐ Yes ☐ No If no, give previous carrier:	

III. CREDITOR/MASTER POLICYHOLDER INFORMATION:

Name of Creditor		Master Policy Agency Number	
Address	City	State	Zip

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison. I hereby certify that the answers given above are true and correct, and I assume full responsibility for statements given. I also certify that I have read and understood the attached Fraud Warning Statement.

Print Name / Title of Creditor's Representative	Signature of Creditor's Representative	
Email Address	Date Signed	Telephone Number

IV. 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	**ICD Code**	Date of Death
Was death due to: ☐ Suicide ☐ Homicide ☐ Accident ☐ Undetermined ☐ Natural Cause		
When was the deceased first consulted for this condition?		Date
How long has the deceased had this condition? _____		
What other conditions contributed to death? _____		
Was an autopsy performed? ☐ Yes ☐ No Was other official inquiry made? ☐ Yes ☐ No		

Address of Attending Physician	City	State	Zip
Telephone Number			
Print Name of Attending Physician			
Signature of Attending Physician		Date	

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, insurance company, group policyholder, employer or benefit plan administrator to provide my credit insurance company named above or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the Claimant named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide my insurance company with financial or employment-related information.

I understand that such information will be used by the insurance company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the term of the policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

I also hereby certify that I have read and understand the attached Fraud Warning Statement.

Date_____ Signature of Claimant/Legal Representative_____ Legal Relationship _____

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 this title.

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 and Washington DC 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.

DETACH AND PROVIDE TO CUSTOMER

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully 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 and 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, West Virginia and Alabama 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, or any combination thereof.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.