Clear Form

Mountain Life Insurance Company
2416 Sir Barton Way Suite 110, Lexington, KY 40509
1-800-888-6542

Credit Death Claim Form

SUBMIT ORIGINAL - DO NOT FAX

NOTE: 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. (In Arkansas) 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.

Name of Deceased Insured _____ Loan Number _____
Certificate No. _____ **Creditor**: Please complete benefit worksheet on the reverse of this form.

Plan of Coverage:	Is this a Renewal of Prior Loan? ☐ Yes ☐ No
☐ Level ☐ Decreasing ☐ Net Balance ☐ Net Balance Balloon	If "Yes," give loan number and amount included in this loan. Loan # _____ Amount $ _____

Second Beneficiary named on Policy/Certificate, if any: _____
(If no second beneficiary is named, any excess benefits will be paid to insured's estate, or as otherwise provided in the policy.)

ATTACHED IS:
1. CERTIFIED COPY OF DEATH CERTIFICATE;
2. COPY OF LOAN APPLICATION, DISCLOSURE STATEMENT & ACCOUNT PAYMENT HISTORY;
3. COPY OF THE POLICY OR CERTIFICATE;
4. COPY OF ANY RENEWAL CONTRACT THAT WAS INCLUDED IN THIS LOAN.

AMOUNT OF CLAIM DUE CREDITOR $_____
AMOUNT OF CLAIM DUE BENEFICIARY $_____
TOTAL AMOUNT OF CLAIM $_____

Certified as complete and correct by: _____ Date _____ Title _____
Signature of Authorized Representative of Creditor

Creditor _____ Phone No. (_____) _____
Area Code

Address _____
Mailing Address City State Zip Code

LIFE CLAIM AUTHORIZATION STATEMENT

(To be completed by Authorized Representative of Deceased, attach copies of appropriate court documents)

Insured's name	Date of Birth
Insured's Social Security Number	Date last worked

Authorized Representative (Print in Full)	Date of Birth	Relationship to Deceased
Address (Street, City, State, Zip)		Telephone Number

Names and addresses of all physicians who attended to deceased and hospitals where treated during the past five years.

Name	Address (Street, City, State, Zip)	Dates	Disease or Condition

I hereby authorize any individual, physician, medical practitioner, hospital, clinic or other medical related facility, Medical Information Bureau, consumer reporting agency, rehabilitative assessment agency or government authority to furnish Mountain Life Insurance Company, its reinsurers or their representatives any information related to the health, medical history, diagnosis, and treatment (including copies of records) concerning the above referenced individual. These records should include any treatment regarding alcoholism, drug abuse, AIDS, HIV testing, AIDS related illness and psychiatric care or any physical or mental condition and/or treatment rendered. This information is to be used for the purpose of determining insurance benefits. This authorization shall be valid for a period of one year from the date of signature.
I also authorize any employer, insurance company or insurance support organization to furnish information regarding benefits to which I may be entitled. I understand that I have a right to receive a copy of this authorization upon request. A Photocopy of this authorization shall be considered as valid as the original.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

_____ _____
Date Signature of Authorized Representative of Deceased

DEATH CLAIM WORKSHEET
FOR CALCULATION OF THE AMOUNT OF THE DEATH BENEFIT

SELECT ONE - BASED ON PLAN OF COVERAGE

LEVEL PLAN OF COVERAGE

LEVEL LIFE COVERAGE – Insurance Does Not Reduce

1. Original Amount of Insurance (1) $_____ = Death Benefit
2. Amount Needed to Payoff Debt on Creditor's Records (2) $_____
3. Amount due Second Beneficiary (Line 1 less Line 2) (3) $_____
4. Amount of Past-Due Charges Due on this Loan $ _____

DECREASING PLAN OF COVERAGE

REDUCING LIFE COVERAGE – Insurance written on "Total of Payments"

1. Original Amount of Insurance (1) $_____
2. Original Term of Insurance = (2) _____ months
3. Monthly Insurance Reduction = (3) $_____
   (Line 1 ÷ Line 2)
4. Number of Monthly Reductions at the time of Death = (4) ____ months
   (Number of Scheduled Loan Payments due prior to death)
5. Total Insurance Reduction Prior to Death (5) $_____
   (Line 3 (x) Line 4)
6. Amount of Insurance in force at Time of Death (6) $_____ = Death Benefit
   (Line 1 less Line 5)
7. Amount Needed to Payoff Debt on the Creditor's Records (7) $_____
8. Amount Due Second Beneficiary, if any (8) $_____
   (Line 6 less Line 7)
9. Total Amount of Past Due Charges or Past Due Payments on this loan:
   Amount $_____, Number of Past Due Payments _____

NET BALANCE AND NET BALANCE BALLOON PLAN OF COVERAGE

NET PAYOFF COVERAGE – Reducing Insurance Written on the "Amount Financed" (Also, use for Net Payoff Balloon)

1. Original Amount of Insurance (1) $_____
2. Original Amount Financed on Contract $_____
3. Scheduled Net Loan Balance on Date of Death (3) $_____
4. Amount Needed to Payoff Debt on Creditor's Records (4) $_____
5. Amount Due Second Beneficiary, if any (5) $_____
6. Total Amount of Past Due Charges or Past Due Payments on this loan:
   Amount $_____, Number of Past Due Payments _____

The amount needed to payoff the debt should not include a refund of the credit life Premium. The premium is fully earned when a credit life claim is paid.

On a net balance loan, the scheduled net loan balance will equal the death benefit only if the original amount of insurance equaled the original amount financed in the loan contract.

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Proposed Insured (Please print)	Social Security Number	Birth Date

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Mountain Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Mountain Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Mountain Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to Mountain Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Mountain Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Mountain Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Mountain Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal data to Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

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