Clear Form

Mountain Life Insurance Company
P. O. Box 240 • 517 Airway Drive • Alcoa, TN 37701
[865] 970-2800 • 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: ☐ Level ☐ Decreasing ☐ Net Balance ☐ Net Balance Balloon	Is this a Renewal of Prior Loan? ☐ Yes ☐ No 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.

MOUNTAIN LIFE INSURANCE COMPANY
P.O. Box 240
Alcoa, Tennessee 37701-0240
800-888-6542

Medical Records Release Authorization

Completion of this Authorization is required in order to consider your application for our insurance or to make a determination of eligibility for benefits on your claim.

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to Mountain Life Insurance Company for the purpose of:

Circle the purpose(s)

1) **Determining eligibility for insurance;**

2) **Determining benefits payable on a disability claim;**

3) **Determining benefits payable on a life claim.**

I understand and agree that Mountain Life Insurance Company may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Mountain Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to:

Mountain Life Insurance Company
P.O. Box 240
Alcoa, Tennessee 37701-0240

This Authorization will expire on _____, or if no date is filled in, twelve (12) months after the date the Authorization is signed.

A photocopy of the Authorization will be as valid as the original for the authorized purpose(s).

_____ _____
Signature of Individual Whose Information is to be Disclosed or Authorized Representative **Date of Birth**

_____ _____
Print Name of Individual **Date**