

SERVICE LIFE AND CASUALTY INSURANCE COMPANY
P O BOX 26800 * AUSTIN, TX 78755-0800
800-299-6977 * (512)343-0600 EXT 3694

INSTRUCTIONS FOR COMPLETING A
CREDIT LIFE CLAIM FORM

WE DO NOT ACCEPT FAXES

There are four sections to this application.

1: Creditor Information

This information is obtained from the insured's payment coupon.

2: Insured's Information

Cause and date of death of the insured will need to be provided.

3: Medical History Information

Please list all of the physicians the insured had seen in the last 10 years.

We must have both the printed name and signature of the applicant.

4. Authorization for the Release of Protected Health Information

Complete the boxed areas only and signature for authorization

Please provide the following documents with this application. Failure to provide these documents may result in a delay in the processing of the claim.

- **Original or a notarized copy of the death certificate.**
- **A copy of the retail installment contract.**
- **A copy of the policy.**

****** Please contact Service Life & Casualty at the above number and not the dealership for any assistance with your claim.**

SERVICE LIFE AND CASUALTY INSURANCE COMPANY
PO BOX 26800 * AUSTIN, TX 78755-0800
512-343-0600 OR 800-299-6977

CLAIM FORM FOR CREDIT LIFE INSURANCE BENEFITS

1. This form must be completed by the spouse or next of kin.
2. Attach an original death certificate or have an original copied and notarized.
3. Attach a copy of the insurance policy and a copy of the Retail Installment Contract (also known as the note)
4. Attach a copy of the letter of testamentary or Will showing the name of the estate administrator, if possible.
5. **Please mail the above information to our address and call within 10 days to verify receipt. We do not accept faxes.**

SECTION 1				
INSURED'S NAME		POLICY NUMBER		LOAN ACCOUNT NUMBER
EFFECTIVE DATE OF LOAN / /	ORIGINAL AMOUNT OF LOAN \$	MONTHLY PAYMENT \$	PAYMENT DUE DATE	REFINANCED? YES OR NO
NAME OF CREDITOR		ADDRESS		CITY ZIP CODE
SECTION 2				
Instructions: With respect to a claim to be submitted in connection with the death of the customer named above, the following portions of this form MUST BE COMPLETED and signed by the surviving spouse or, if none, by the next of kin. Failure to complete and sign this form could delay your claim.				
DATE OF DEATH		CAUSE OF DEATH		OCCUPATION
IF DEATH OCCURRED IN A HOSPITAL, PLEASE INDICATE NAME OF HOSPITAL				
ADDRESS		CITY	STATE	ZIP CODE
OTHER HOSPITAL, MEDICAL FACILITIES RESPONSIBLE FOR TREATMENT				
ADDRESS		CITY	STATE	ZIP CODE
SECTION 3				
INSTRUCTIONS: List the family physician and any other physician that treated the deceased during the past 5 years				
FAMILY PHYSICIAN		PHYSICIAN		
ADDRESS		ADDRESS		
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE		
PHONE NUMBER		PHONE NUMBER		
PHYSICIAN		PHYSICIAN		
ADDRESS		ADDRESS		
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE		
PHONE NUMBER		PHONE NUMBER		
The answers above are true and completed to best of my knowledge and belief. I authorize and release to Service Life and Casualty Insurance Company (or authorized representative) any medical or other information that may be required for their use in establishing the validity of the claim. A photocopy of this authorization shall be considered effective and valid as the original. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENT FALSE INFORMATION ON AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.				
NEXT OF KIN (PLEASE PRINT NAME)			PHONE#	
ADDRESS OF NEXT OF KIN		CITY	ST.	ZIP CODE
SIGNATURE OF NEXT OF KIN			RELATION TO THE DECEASED	

**SERVICE LIFE AND CASUALTY INSURANCE COMPANY
P.O. BOX 26800, AUSTIN, TX 78755-0800**

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

*PLEASE RETURN THIS FORM BACK TO SERVICE LIFE WITH YOUR CLAIM FORM

PLEASE COMPLETE THE BOXED AREAS ONLY

This authorization form has been specifically designed to comply with all state and federal regulations pertaining to the confidentiality of health information.

I authorize (Name of Medical and/or Healthcare provider.) _____
(do not provide names)
to release information and/or copies of medical records for the following patient:

Patient Name: _____	DOB _____
SS#: _____	Address: _____

Specific Information to be released:

<input checked="" type="checkbox"/> ER REPORT	<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> History & Physical
<input checked="" type="checkbox"/> Consultation	<input checked="" type="checkbox"/> X-ray Report	<input checked="" type="checkbox"/> Pathology Report
<input type="checkbox"/> Lab	<input checked="" type="checkbox"/> Clinic/Progress Note	<input checked="" type="checkbox"/> Operative Report

Dates of Treatment(s) _____ to _____ (do not provide dates)

Purpose of Disclosure: Credit Life Insurance Benefits

I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing or AIDS information. _____ Initial

Records are be released to Service Life and Casualty Insurance Company,
PO Box 26800, Austin, TX 78755

This authorization is valid for 180 days from date of signing and may be revoked at any time by sending a written request prior to the expiration date to the provider named above. Revocation of this authorization shall not affect releases of information made prior the revocation. I understand that authorizing the disclosure of my protected health information is voluntary. I further understand that the disclosure of this information carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by Federal Confidentiality Rules.

I understand that my treatment or payment can not be conditioned at the above healthcare provider/medical facility and will not be affected if I decide not to sign this authorization.

SIGNATURE OF LEGAL NEXT OF KIN _____
Date _____
RELATION TO THE DECEASED _____

Copies of this original signed authorization will be considered valid and provided to all health care providers.

Service Life and Casualty Insurance Company

P. O. Box 26800 * Austin, Texas 78755

(800) 299-6977

CONSENT FOR COMMUNICATION

Pursuant to the Graham-Leach-Bliley Act, Service Life and Casualty Insurance Company (SLC) must adhere to certain guidelines in handling Credit Insurance claims. Please read each paragraph and initial that you understand and give consent for the following:

I, _____,
understand that I have filed a **credit life claim** on behalf of the estate of:

() and hereby authorize any physician, hospital, government agency, insurance company, workers' compensation carrier or organization to release to Service Life and Casualty Insurance Company information regarding medical history/treatment as well as past and present employment status of the above named deceased.

() and hereby authorize the creditor

_____ to
speak with Service Life and Casualty Insurance Company regarding the vehicle loan account of the above named deceased.

() and hereby authorize one other person other than myself to speak on my behalf regarding the claim with Service Life and Casualty Insurance Company. This person shall be named:

_____.

PLEASE INITIAL IN THE SPACES () BY EACH PARAGRAPH THAT YOU HAVE READ AND UNDERSTAND EACH CONSENT. PRINT YOUR NAME, THE NAME OF THE CREDITOR, AND THE NAME OF YOUR REPRESENTATIVE IN THE SPACES PROVIDED.

Please sign your name

Date

Slc (10/06) This form shall remain valid through the life of the claim.