AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE CLAIMS DEPARTMENT
P.O. BOX 4328, SPRINGFIELD, MO 65808-4328
PHONE NUMBER: 800-899-6502
FAX NUMBER: 409-766-2912
E-MAIL: CIDCLAIMSDEPT@AMERICANNATIONAL.COM

CREDIT LIFE CLAIM FORM INSTRUCTIONS

Enclosed are forms required to process a claim for credit life benefits. **These forms must be completed by the surviving spouse, if none, by the personal representative, if none, by the informant listed on the death certificate, or the next of kin.**

Checklist for all items to include with the completed claim form for Credit Life Benefits:

_____ certified or notarized copy of death certificate
_____ copy of insurance policy/certificate
_____ copy of insured's retail installment contract
_____ any affidavit of heirship, letters of testamentary, probate documentation, or any other legal documentation indicating executor of the insured's estate, if applicable
_____ copy of payment history from the creditor
_____ completed "Next of Kin Authorization" or any other legal documentation indicating executor of the insured's estate
_____ completed "Statement of Medical History"
_____ executed "Consent for Communication" authorization
_____ completed "HIPAA Authorization"
_____ completed and notarized "Affidavit in Support of Medical Records"

Please note: If any of the above sections are left blank, the form will be returned causing a delay in processing your paperwork for payment. Your cooperation in this matter will help speed your claim processing. Claim payments are made to the creditor beneficiary named in the Schedule to pay off or reduce the debt. If claim payments are more than the balance of the debt, the difference will be paid by separate company check to the second beneficiary named in the Schedule or to the estate. Please mail your completed form and attachments to the address below. FAXES and e-mails are accepted; however, originals may be required at any time.

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If you have any additional questions, we can be reached at **1-800-899-6502**. Our business hours are from 8:00 a.m. to 4:30 p.m., Central Standard Time.

FRAUD WARNINGS/STATEMENTS

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska - 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 state law.

Arizona - Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia - 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 fines and confinement in prison.

California - Any person who knowingly presents 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.

Colorado - 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.

Delaware - Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Florida - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - 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 - 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.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

Minnesota - A person who files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

New Hampshire - 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 RSA 638:20.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - 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.

Ohio, Oregon - 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 - "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."

Pennsylvania - 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 - 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.

Tennessee, Maine, Virginia, Washington - 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.

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CLAIM FORM FOR CREDIT LIFE BENEFITS

1. Section 1 of this form must be completed by the surviving spouse, if none, by the personal representative, if none, by the informant listed on the death certificate, or next of kin.
2. Section 2 of this form must be completed by the creditor or lender.

SECTION 1

Principal Insured's Name _____ Social Security Number _____

Joint Insured's Name _____ Social Security Number _____

Name of Deceased _____ Principal ☐ Joint ☐ Policy/Certificate Number _____

Is there a current disability claim pending on this loan? Yes ☐ No ☐ Claim Number _____

Date of Death: _____ Cause of Death: _____ Occupation: _____

Date Insured last worked: _____ When did Insured first consult a physician for last illness: _____

When did Insured first complain or give indication of last illness: _____

I hereby certify that the information shown above is true and complete to the best of my knowledge and belief.

Signature of Next of Kin	Relationship to Deceased	Date

Address	City	State	ZIP	Phone Number

SECTION 2 –COMPLETED BY CREDITOR OR LENDER

Effective Date of the Loan: _____ Refinanced? Yes ☐ No ☐ Original Loan Amount $ _____

Term (Months) _____ Monthly Payment $_____ Date of First Payment $_____

Net Unpaid Balance Due Creditor $_____ Payoff good through: _____

Per Diem $_____ (Please attach a copy of the FULL payment history)

Name of Creditor: _____ Loan/Account Number: _____

Creditor Address: _____

Creditor Phone Number: _____ Completed by: _____

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NEXT OF KIN AUTHORIZATION

To Whom it May Concern: You are authorized to permit American National Insurance Company (the Company) and its subsidiaries to view and obtain a copy of records pertaining to any and all medical practitioners, physicians, pharmacists, pharmacy benefit managers, hospitals, clinics, nurses, records custodians, employers, financial custodians, law enforcement agencies, or insurance companies of _____ who died on _____. I understand that the information I am authorizing to be released may include:

1. AIDS/HIV test results, diagnosis, treatment, and related information;
2. Drug screen results and information about drug or alcohol use and treatment;
3. Mental health information; and/or
4. Pharmacy prescriptions/Pharmacy Benefits Managers.

I further understand that this authorization is valid for one year from the date executed below. I also understand that I may revoke this authorization at any time during the one (1) year period by notifying the Claims Department in writing at the address shown at the top of this form. The information obtained by this authorization will be used to evaluate this claim. The information obtained by this authorization may be disclosed to reinsurance companies, if policy/certificate is reinsured, to any agency employed by the Company, and to any party to which the Company is required by law or subpoena to disclose. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance.

You may honor a photographic copy of this authorization.

I certify under penalty of perjury that the information and Social Security Number(s) provided below are true and correct. I understand that if I refuse to sign this authorization to release the complete medical records for the insured, the insurance company may not be able to process benefit payment requested under this policy/certificate.

Signed by Next of Kin X _____this ____day of_____, _____.

_____	_____	_____
Relationship to Deceased	**Deceased's Social Security Number**	**Deceased's Date of Birth**

Please Print Next of Kin's Name _____Phone Number _____

Please Print Next of Kin's Address_____
Street City State ZIP

Next of Kin's Date of Birth _____Next of Kin's Social Security Number _____

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STATEMENT OF MEDICAL HISTORY

Insured: _____ Claim Number: _____

Please provide the names, addresses, telephone numbers, and dates of service for all of the physicians, hospitals, and pharmacies, which provided treatment for the Insured within the past 5 years. Failure to do so may cause a delay in processing the claim. Please use the reverse side of this form for additional names.

PRIMARY CARE PHYSICIAN:

Name _____ Address _____
(Street)

Phone Number ( ) _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone Number ( ) _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

OTHER PHYSICIANS and/or HOSPITALS:

Name _____ Address _____
(Street)

Phone Number ( ) _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone Number ( ) _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

STATEMENT OF MEDICAL HISTORY - CONTINUED

PHARMACY: _____ Address _____
(Street)

Phone Number ( ) _____ _____
(City, State, ZIP)

PHARMACY: _____ Address _____
(Street)

Phone Number ( ) _____ _____
(City, State, ZIP)

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CONSENT FOR COMMUNICATION

Pursuant to the Graham-Leach-Bliley Act, American National Insurance Company 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 for the insured named below:

_____ .

( ) and hereby authorize any physician, hospital, government agency, insurance company, workers' compensation carrier or organization to release to its administrator, American National Insurance Company, information regarding the medical history/treatment and any past or present employment status on the named insured.

( ) and hereby authorize the creditor, _____, to speak with its administrator, American National Insurance Company, regarding the loan account on the named insured.

Please initial the spaces ( ) by each paragraph that you have read and understand each consent. Print the name of the insured party, the name of the creditor, and your name and relationship as representative of the insured in the spaces provided.

_____	_____	_____
Please sign your name	Relationship to Insured	Date

This form shall remain valid through the life of the claim.

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AUTHORIZATION

This authorization is designed to comply with the HIPAA Privacy Rule.

TO THE NEXT OF KIN: During the claim and as a part of the claim proof requirements of the policy, American National Insurance Company (the Company) will need information to determine the eligibility for benefits. All information we obtain with this Authorization will be kept confidential. Please immediately complete, sign, date, and return this Authorization to help us promptly consider the claim. Any alteration to or limitation of this Authorization will prejudice the Company's right to independently evaluate the claim and may prevent benefits from being provided.

I AUTHORIZE THESE PERSONS OR ENTITIES HAVING ANY KNOWLEDGE OF THE INSURED'S HEALTH:
Physician, therapist, healer, or medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, or other medically related facility or association * other health care provider * insurance company or insurance support organization * employer, business associate, group health plan, or administrator * law enforcement agency * Social Security Administration * agency, organization, or entity administering a benefits program * educational, vocational, or rehabilitation organization, financial institution, bank, accountant, tax preparer, attorney, or * other persons or institutions.

TO PROVIDE THE FOLLOWING INFORMATION TO COMPANY OR ITS AUTHORIZED REPRESENTATIVES:
- The insured's complete patient file and entire medical record including any charts, notes, x-rays, operative reports, lab, and medication records, copies of all prescriptions, and all other medical information about the insured including medical history, diagnosis, testing and test results, consultation reports, prognosis, and treatment of any physical condition, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes, communicable disease or disorders, sexually transmitted disease, mental, psychiatric, or psychological condition including test results, drug, alcohol, or other substance abuse including treatment or therapy;
- Non-medical information about the insured, including information concerning education, occupation, employment history, earnings, finances, unemployment benefits, applications for insurance, or eligibility for other benefits;
- Social Security information concerning the insured, including detailed information regarding earnings for up to ten (10) years, and/or a summary record of total earnings, and/or information from master benefits records regarding the award, denial, or continuation of benefits.

I UNDERSTAND, ACKNOWLEDGE, AND AGREE TO THE FOLLOWING PROVISIONS:
No Restrictions: Any agreements the insured has made to restrict protected health information does not apply to this authorization, and I instruct the persons or organizations identified in paragraph two (2) above to release and disclose the entire medical record without restriction. **Purpose**: The Company will use the information to (1) properly evaluate the claim and determine eligibility for coverage; and (2) conduct other legally permissible activities. **Use**: In the course of conducting its business, the Company may disclose to other parties information about the insured. The Company may release this information about the insured to affiliates, reinsurers, and any person performing business or legal services for the Company. The information disclosed pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule and may be redisclosed pursuant to this Authorization or otherwise as permitted or required by law. **Right to Revoke**: I have the right to revoke this Authorization at any time by sending a written statement to the Company, Credit Insurance Claims Department, at P. O. Box 4328, Springfield, MO 65808-4328, except to the extent it has been relied upon to disclose requested records. **Expiration**: This authorization will remain in effect for a maximum of twelve (12) months from the date of signature below. **Copy**: I, the authorized representative, have a right to receive a copy of this Authorization. A photocopy or facsimile of this authorization is as valid as the original. I understand that if I refuse to sign this authorization to release the insured's complete medical records, the Company may not be able to process benefit payments requested under the policy.

I understand any false statement made knowingly and willfully to obtain information from federal records is punishable by fine, imprisonment, or both.

SIGNATURE OF NEXT OF KIN	DATE	RELATIONSHIP TO INSURED
PRINT NAME OF INSURED	DATE OF BIRTH	SOCIAL SECURITY NUMBER

POLICY/CERTIFICATE NUMBER

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AFFIDAVIT IN SUPPORT OF MEDICAL RECORDS REQUEST (FOR DECEASED PATIENTS)

With regard to American National Insurance Company's request for medical records of:

Name of Deceased _____, Date of Birth _____, SSN_____

(hereinafter decedent),

I hereby swear or affirm that I am:

____ the executor, administrator, personal representative, or trustee of decedent's estate named by decedent, and I know of no facts or circumstances that would disqualify me from serving in that capacity. (Attach copy of documents evidencing appointment.)

OR

No personal representative has been appointed for the decedent's estate in this state or elsewhere, and no application for such an appointment is pending in the state or elsewhere, and I hereby swear or affirm that I am:

____ Spouse. The surviving spouse of decedent.

____ Child. A natural or adopted child of decedent and at least 18 years of age, and decedent left no surviving spouse.

____ Parent. A natural or adopted parent of decedent, and decedent left no surviving spouse or natural or adopted children 18 years of age or older.

____ Brother or sister. A natural or adopted sibling (not step-sibling) of decedent, and decedent left no surviving spouse or natural or adopted child or parent.

_____ _____
Signature Date

Subscribed and sworn before me on this _____ day of the month of _____20___.

_____ My commission expires _____
Notary Public

(Seal)