Arkansas Bankers Life Insurance Company
3616 Jefferson Avenue • Texarkana • AR • 71854

To file a Death Claim, please furnish the following:

••• Certified Copy of the Death Certificate

••• Name, Address & Account # of Creditor: _____
Creditor's Name

_____
Mailing Address *City* *State* *Zip*

_____
Account Number

••• Current Net Pay-off Amount $_____ Daily Accrual (if any) $ _____
(*You will need to obtain this information from the Creditor*)

••• Arkansas Bankers Life Insurance Company's "Claim for Credit Life Death Benefits" Form

••• "Authorization for Release of Health-Related Information" Form (HIPAA compliance)

••• "Affidavit in Support of Medical Records Request"

••• Department of Veterans Affairs "Request to Release Medical Records" (only if the VA has medical records on insured)

••• Copy of Credit Life Insurance Policy. If not available, please provide additional information to assist us in locating the coverage:

Policy #_____ Date Purchased _____

Where Purchased _____

Please return all forms and information to:
Arkansas Bankers Life Claims Department, 3616 Jefferson Ave, Texarkana AR 71854
800 451-2636 - 870 773-7221 - 870 772-7324 (Fax)

Arkansas Bankers Life Insurance Company
3616 Jefferson Avenue, Texarkana AR 71854

Claim for Credit Life Death Benefits

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.

_____ _____

Name of Insured Complete address

AUTHORIZATION TO BE COMPLETED BY NEXT OF KIN

Date insured last worked _____ When did insured first complain of or give other indication of last disease? _____ When did insured first consult a physician for last illness ?_____

Give the name, complete address and phone number of insured's primary doctor and any other physicians, hospital or practitioners who attended to insured or prescribed medications within the last three years.

Name	Address	Telephone	Date of Attendance	Disease or Condition

The statements above are true, accurate and complete. I agree that Arkansas Bankers Life Insurance Company may rely upon them as part of the proof of death for insurance policies issued to the insured and authorize them to pay benefits as determined by said credit life insurance.

_____

Signature of Next of Kin Relationship to Insured Date

_____

Address City State Zip Telephone #

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Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

(Print full name and birth date)

Insured's Name	Date of Birth	SS# /Medical Record #

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided treatment or services to the above-mentioned deceased patient to disclose medical records and any other protected health information to Arkansas Bankers Life Insurance Company (ABL) and its agents, employees, and representatives.

By the signature below, I acknowledge that any agreements made to restrict 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 the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that ABL may administer and process claims and determine or fulfill responsibility for coverage and provision of benefits.

This authorization shall remain in force for 12 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 sending a written request for revocation to ABL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any provider has relied on this authorization or to the extent that ABL 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 may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that 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 complete medical records, ABL may not be able to process this death claim or make any benefit payments. I have received a copy of this authorization.

Signature of Next of Kin or Personal Representative	Date

Please return this form and the Attachment to the address above

Arkansas Bankers Life Insurance Company
3616 Jefferson Avenue
Texarkana AR 71854

AFFIDAVIT IN SUPPORT OF MEDICAL RECORDS REQUEST
(for DECEASED INSURED)

With regard to Arkansas Bankers Life Insurance Company's request for medical records/ pharmacy records of NAME_____, DOB_____, SSN_____ (hereinafter decedent),

I hereby swear or affirm that I am:

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

OR

No personal representative has been appointed for the decendent's estate in this state or elsewhere and no application for such an appointment is pending in the state or elsewhere, and 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)

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial) SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

Attachment for HIPAA Release form

Please make sure you list all Physicians/Hospitals that treated the insured the past 3 years. Failure to do so may cause a delay in processing your claim.*

_____

Insured's Name

DOCTOR , CLINIC & HOSPITAL INFORMATION

1

Name: _____
Address: _____
_____
Phone Number: _____
Date of First Visit: _____
Date of Last Visit: _____

2

Name: _____
Address: _____
_____
Phone Number: _____
Date of First Visit: _____
Date of Last Visit: _____

#3

Name: _____
Address: _____
_____
Phone Number: _____
Date of First Visit: _____
Date of Last Visit: _____

4

Name: _____
Address: _____
_____
Phone Number: _____
Date of First Visit: _____
Date of Last Visit: _____

#5

Name: _____
Address: _____
_____
Phone Number: _____
Date of First Visit: _____
Date of Last Visit: _____

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