Union Security Life Insurance Company of New York

Administrative Office
P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085 • Fax 305.252.6910
Attn: DFS Claims Department

CREDIT LIFE DEATH CLAIM FORM
NET PAYOFF/CLOSED END MONTHLY OUTSTANDING BALANCE/ AD&D/GROSS DECREASING/LEVEL

All benefit payments are paid directly to your creditor.

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

☐ **1. Have person reporting claim complete Section B.**

☐ **2. Attach a copy of the Certified Death Certificate.**

☐ **3. Have Section C or D completed by your creditor or financial institution where the coverage was purchased.**
- **Complete Section C for Net/Payoff/Closed End Monthly Outstanding Balance**
- **Complete Section D for AD&D, Gross Decreasing or Level**

☐ **4. Attach a copy of Certificate of Insurance and Application for Credit Insurance, if applicable.**

☐ **5. Attach Ledger Card or Statement of Account at date of death.**

☐ **6. Complete attached Health Insurance Portability and Accountability Act (HIPAA) Authorization.**

☐ **7. Follow your creditor's instructions for mailing the completed claim form.**

- **To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.**

Fax completed form and all supporting documentation to 305.252.6910 or mail to:

DFS Claims Department
PO Box 977122
Miami FL 33197-7122

ONCE YOUR CLAIM IS RECEIVED

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

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A. DEATH CERTIFICATE

Attach a copy of the certified death certificate.

B. PERSON REPORTING CLAIM

PLEASE PRINT

This section must be completed if death occurred within 2 years of policy effective date.

Names and addresses of all physicians who attended deceased during last illness and during the five years prior to death:

NAME	STREET ADDRESS / CITY / STATE / ZIP CODE	TELEPHONE NUMBER	DATE OF ATTENDANCE	DISEASE OR CONDITION
		( )	/ /	
		( )	/ /	

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization, or person having any records, data or information concerning this claim to furnish such record, data or information to the insurance company issuing my policy as requested. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If, in fact, the furnished information is false, thereby inducing payment of claim, and the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give to the insurance company issuing my policy the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall remain valid for the duration of the claim.

WARNING: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties.

PRINT NAME	SIGNATURE	RELATIONSHIP TO DECEASED	DATE
	X		/ /

STREET ADDRESS / APT #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

C. CREDITOR'S STATEMENT - Net Payoff/Closed End Monthly Outstanding Balance

PLEASE PRINT

1. Please attach a copy of the Certified Death Certificate, Payoff Statement, Ledger Card, Insurance Certificate/Policy and Application for Credit Insurance, if applicable.

2. FULL NAME OF DECEASED

3. POLICY/CERTIFICATE NO. (INCLUDE PREFIX)	4. DATE OF ISSUE MO/DAY/YEAR	5. TERM (Mos) INS.	5. TERM (Mos) LOAN	6. LOAN APR	7. TYPE LOAN	8. AGENT CODE	9. INS. EXPIRES MO/DAY/YEAR
	/ /				☐ Simple Interest ☐ Precomputed		/ /

10. Health questions used ☐ Yes ☐ No **If yes, attach copy of completed application.**

BENEFIT CALCULATION

11. If Precomputed Loan (see item 7 above) — Check method of Interest Rebate: ☐ Rule of 78s ☐ Actuarial

12. Initial amount of Insurance (Principal Amount of Loan) . . . . . $ _____

13. Net Payoff Balance of Loan at Date of Death
Amount is after deduction of all unearned credit insurance products other than credit life ☐ Yes ☐ No . . . . . $ _____

14. Less any Principal Amount Included in Line 13 over 60 days delinquent . . . . . $ _____

15. Amount due to First Beneficiary (Creditor) (Line 13 minus Line 14) . . . . . $ _____

16. Payments made, prior to but, not scheduled until after the date of death . . . . . $ _____

17. NAME OF SECOND BENEFICIARY			DATE OF BIRTH / /
18. STREET ADDRESS / APT #	CITY	STATE	ZIP CODE
19. NAME OF DEALER OR BRANCH WHERE INSURANCE WAS PURCHASED (if applicable)			DEALER NUMBER
20. FIRST BENEFICIARY / CREDITOR	FAX NUMBER ( )		TELEPHONE NUMBER ( )
21. STREET ADDRESS	CITY	STATE	ZIP CODE
22. NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE X		DATE / /

D. CREDITOR'S STATEMENT – AD&D, Gross Decreasing or Level

PLEASE PRINT

1. Please attach a copy of the Certified Death Certificate, Payoff Statement, Ledger Card, Insurance Certificate/Policy and Application for Credit Insurance, if applicable.

2. FULL NAME OF DECEASED

3. POLICY/CERTIFICATE NO. (INCLUDE PREFIX)	4. DATE OF ISSUE MO/DAY/YEAR	5.TERM IN MONTHS	6. FIRST PAYMENT DUE DATE	7. POLICY/CERT. EXPIRES MO/DAY/YEAR	8. AGENT CODE
	/ /		/ /	/ /	

9. Health questions used ☐ Yes ☐ No **If yes, attach copy of completed application.**

BENEFIT CALCULATION

10. Initial Amount of Insurance Coverage . . . . . $ _____

11. If Decreasing Coverage, Amount of Decrease
(_____) ÷ (_____) = (_____) x (_____) = ... $ _____
Initial Amt. (Line 10) Term (Line 5) Monthly Decrease Mos. in Effect

12. Amount of Insurance Coverage at Date of Death (Line 10 minus Line 11) . . . . . $ _____

13. Less Amount claimed by First Beneficiary (Creditor) (Net Balance Due)
Amount is after deduction of all unearned credit insurance products other than credit life ☐ Yes ☐ No . . . . . $ _____

14. Balance, if any, payable to Second Beneficiary (Line 12 minus Line 13) . . . . . $ _____

15. NAME OF SECOND BENEFICIARY			DATE OF BIRTH / /
16. STREET ADDRESS / APT #	CITY	STATE	ZIP CODE
17. NAME OF DEALER OR BRANCH WHERE INSURANCE WAS PURCHASED (if applicable)			DEALER NUMBER
18. FIRST BENEFICIARY / CREDITOR	FAX NUMBER ( )		TELEPHONE NUMBER ( )
19. STREET ADDRESS	CITY	STATE	ZIP CODE
20. NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE X		DATE / /

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Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following information to Union Security Life Insurance Company of New York.

INSURED INFORMATION

NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	DAYTIME TELEPHONE NUMBER
	- -	/ /	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION:

NAME	DAYTIME TELEPHONE NUMBER
	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

DESCRIPTION OF INFORMATION TO BE RELEASED

ENTIRE MEDICAL RECORD	HIV/AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT
☐ Yes ☐ No	☐ Yes ☐ No

OTHER

I UNDERSTAND THAT:

a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization.

b. 1. This Authorization will expire without any action by me one year after the date of my signing below.
2. This Authorization shall be valid for the duration of the claim **(Arizona residents only)**.

c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.

d. This authorization is voluntary and I have the right to refuse to sign it.

e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.

f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.

h. I agree that a photocopy of this authorization shall be as valid as the original.

i. I, or my authorized representative, have the right to receive a copy of this authorization.

YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE)	DATE
X	/ /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MAY BE REQUIRED)

ONE FORM MUST BE COMPLETED FOR EACH MEDICAL PROVIDER
Please photocopy this form if you need additional copies.