CREDIT INSURANCE GENERAL AGENCY

P.O. BOX 1580, MANDEVILLE, LA 70471

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY BEFORE CLAIM CAN BE PROCESSED

Section A.

STATEMENT OF ASSIGNEE — CREDITOR — MUST BE COMPLETED IN FULL TO SECURE PAYMENT

Group Policy Number (Name of Insured) Social Security Number

DATE OF NOTE	AMOUNT OF NOTE	LOAN ACCOUNT NO.	BORROWER'S* INSURANCE CERTIFICATE NO.	HOW PAYABLE?	BALANCE DUE
				(1) MOS. @ $ (3) MOS. @ $ (2) MOS. @ $ (4) MOS. @ $	

ATTACHED: Certified Copy of Death Certificate ☐ Creditor's Copy of Certificate ☐ Copy of Note or Contract ☐

This is a (check one) ☐ Death Claim ☐ First Claim ☐ Continuing Claim

Type of Coverage

Life	☐ Level Term ☐ Reducing Term ☐ Joint Life (Reducing Term)	**A & H** Retroactive	Elimination
Premium		☐ 7 Day	☐ 7 Day
Life _____		☐ 14 Day	☐ 14 Day
A&H _____		☐ 30 Day	☐ 30 Day

Amount Due Creditor Beneficiary $_____

Amount Due Second Beneficiary $_____

ASSIGNEE — CREDITOR_____ **REMARKS:**_____

SIGNED_____ **DATE**_____

CREDITOR REPRESENTATIVE CITY STATE ZIP

Section B

STATEMENT OF THE INSURED—CLAIMANT

NAME (PLEASE PRINT)	ADDRESS SOCIAL SEC. NO.:	DATE OF BIRTH
	NO. & STREET CITY STATE ZIP	

OCCUPATION | PRESENT EMPLOYER (IF SELF-EMPLOYED DESCRIBE OCCUPATION)

BUSINESS ADDRESS OR EMPLOYER'S ADDRESS

DATE OF SICKNESS OR ACCIDENT	DATE TOTAL DISABILITY BEGAN	DATE YOU FIRST RETURNED TO WORK?

DIAGNOSIS OF SICKNESS OR DESCRIPTION OF INJURIES

HAVE YOU EVER BEEN TREATED FOR A SIMILAR CONDITION OR INJURY?

WHEN BY WHOM

IF INJURY HOW AND WHERE DID ACCIDENT HAPPEN?

NAME OF PHYSICIANS	ADDRESS	DATE OF FIRST TREATMENT
NAME OF HOSPITAL	**ADDRESS**	**DATE ADMITTED-DISCHARGED**

AUTHORIZATION TO RELEASE INFORMATION

I hearby assign to the creditor named above to the extent of its interest as creditor, any indemnity payable under this claim, and authorize any hospital, physician, or other person who has attended me or examined me, to furnish to the North American Insurance Company and/or American National Insurance Company, or its representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions of treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

APPROVED BY:_____ DATED_____ 20_____

_____ _____ SIGNED: X_____

ATTENDING PHYSICIAN CLAIMANT'S SIGNATURE (IF MINOR, PARENT'S SIGNATURE)

Form CG—401 (2/83)

Section C

ATTENDING PHYSICIAN'S STATEMENT - ACCIDENT OR SICKNESS -

Patient's Name	Age
Nature of sickness or injury (Describe Complications if any.) ☐ Acute ☐ Chronic ☐ Recurrent	
When did symptoms first appear or accident happen?	Date 20
When did patient first consult you for this condition?	Date 20
If patient previously had medical attention, state by whom.	Name Address
Has patient ever had same or similar condition?	Yes ☐ _____ Years No ☐ _____ Months _____ Weeks History:
Describe any other disease or infirmity affecting present condition.	
Nature of surgical procedure, if any (Describe fully)	
Give dates of treatment.	Office: Home: Hospital:
Is patient still under care for this condition? If discharged, give date.	Yes ☐ No. ☐ Date 20
If patient hospitalized, give name and address of hospital.	Admitted 20 Discharged 20 (Also show name and address of hospital)
How long was or will patient be continuously totally disabled (unable to work)?	From 20 through 20
How long was or will patient be partially disabled?	From 20 through 20
If sickness, was patient confined to the house? (If "yes" give dates)	Yes ☐ No ☐ From 20 through 20
For what have you previously treated patient? (State conditions and dates)	

REMARKS The hospital, if insured was hospitalized, is hereby authorized to furnish, with insured's consent, any information requested

Date _____, 20 _____ Signed _____ Degree
(ATTENDING PHYSICIAN)

(STREET ADDRESS) (CITY OR TOWN) (ZONE) (STATE)

Section D

STATEMENT OF EMPLOYER

When did he cease work?	Date	Hour	A.M.	P.M.
On what date did he return to any part of his work, supervisory or otherwise?	Date	Hour	A.M.	P.M.

SIGNATURE _____ DATE _____ 20____
OFFICIAL POSITION

EMPLOYER:
COMPANY NAME _____
NUMBER AND STREET CITY STATE