AssurantGroup

American Bankers Life Assurance Company of Florida
Voyager Life and Health Insurance Company
Voyager Life Insurance Company
MS Life Insurance Company
Life of Mississippi Insurance Company

P.O. Box 6018
Ridgeland, MS 39158-6018
Telephone: 1.800.333.5043

CENTRAL PROCESSING SERVICES

LIFE CLAIM FORM

INSTRUCTIONS

1. *Complete this form in full.*
2. *Attach a certified copy of the death certificate showing cause and manner of death.*
3. *Attach a copy of the insurance certificate and/or contract showing the second beneficiary designation.*

NOTE: If unusual circumstances were involved, please submit newspaper clippings and/or the police report.

FOR CLAIM DEPARTMENT USE ONLY	
CLAIM NUMBER	
DATE RECEIVED / /	PRODUCER NUMBER
SET UP	BY
ACTION DATE / /	BY
AMOUNT $	
REMARKS	

INSURED'S NAME AND ADDRESS			☐ Single ☐ Joint	ANNUAL PERCENTAGE RATE
LOAN/ACCOUNT NUMBER	CREDIT LIFE PREMIUM $	MONTHLY PAYMENT $	EFFECTIVE DATE / /	INS. TERM
CERTIFICATE NO.	PRODUCER/LOC. NO.	ORIGINAL AMOUNT OF INSURANCE $		AMOUNT FINANCED $
DATE OF FIRST PAYMENT / /	DATE OF DEATH / /	PRIOR A&H CLAIM NUMBER (IF APPLICABLE)		INSURED'S AGE
RENEWAL ACCOUNT ☐ Yes ☐ No If so, earliest date of coverage __/__/__		☐ Net Plus 1 ☐ Net Plus 3	PLAN OF INSURANCE ☐ Outstanding Balance ☐ AD&D ☐ Decreasing ☐ Level ☐ Net Balance	
NAME AND ADDRESS OF CREDITOR BENEFICIARY			SOCIAL SECURITY NUMBER	
STREET/P.O. BOX NUMBER				
CITY	STATE	ZIP	TELEPHONE NUMBER	

1. Original Amount of Insured's Coverage $ ________________
2. Amount Claimed by Creditor (Principal Balance as of Date of Death) $ ________________
3. Amount to be Paid to Second Beneficiary $ ________________

I hereby certify that the information shown above is true and complete.

SIGNATURE OF CREDITOR REPRESENTATIVE	DATE
X	/ /

STOCK # 1372-0200

CLAIM NO.

Have the deceased insured's next of kin complete and sign the following:

NEXT OF KIN AUTHORIZATION

Give names and addresses of any physician, hospital, organization, or other person who has attended the deceased insured.

NAME	ADDRESS

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, or other organization or person having any records, data, or information concerning the deceased insured to furnish such record, data, or information to **VOYAGER INSURANCE COMPANIES** or any of its subsidiaries or its authorized representative(s) 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 the deceased insured's 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 **Voyager Insurance Companies** or any of its subsidiaries determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, **Voyager Insurance Companies** may furnish the needed 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 **Voyager Insurance Companies** or any of its subsidiaries the right to void the deceased insured's policy.

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

SIGNATURE (NEXT OF KIN)			DATE
X			/ /
NAME AND ADDRESS OF SECOND BENEFICIARY OR ADMINISTRATOR OF THE ESTATE		SOCIAL SECURITY NO.	RELATIONSHIP
STREET/P.O. BOX NUMBER			
CITY	STATE	ZIP	TELEPHONE NUMBER

WARNING: Pursuant to the laws of all states except as noted below: "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 may subject such person to criminal and substantial civil penalties.

CA residents only – For your protection California law requires the following to appear on this form. 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 or confinement in state prison.

DC residents only – Warning: It is a crime to provide fake or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if fake information materially related to a claim was provided by the applicant.

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

NH residents only – 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. However, the lack of such a statement shall not constitute a defense against prosecution under RSA 638:20.

NJ residents only – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY residents only – 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

OK residents only – Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

VA residents only – 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.