AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION
P. O. BOX 696785 * SAN ANTONIO, TEXAS 78269-6785
800-899-6502

CREDIT LIFE CLAIM FORM INSTRUCTIONS

Enclosed is a form required to process a claim for credit life benefits. It is important that all questions be fully answered to avoid possible delay in the processing of your claim.

Section 1 – This information is obtained from the insured's payment coupon book, statement, monthly billing from the creditor, retail installment contract, and payment history.

Section 2 – This is the insured's information where the next of kin is asked to provide the cause and date of death of the insured.

Section 3 – Please list all of the physicians the insured has seen in the last 5 years. You may attach a separate sheet if additional space is needed.

Next of Kin Authorization and HIPAA Authorization form

The next of kin or personal representative should complete the page entitled "Next of Kin Authorization" and the HIPAA Authorization form.

Checklist for additional items to include with your completed Credit Life Benefits claim form:

_____ certified or notarized copy of death certificate
_____ copy of insurance policy
_____ copy of insured's retail installment contract
_____ executed "Next of Kin" and HIPAA authorization forms
_____ any affidavit of heirship, letters of testamentary, probate documentation, or any other legal documentation indicating executor of the insured's estate
_____ copy of your payment history from your creditor
_____ executed "Consent for Communication" authorization

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. All payments will be made to the creditor. Please mail your completed form and attachments to the address below. **We cannot accept FAXES.**

American National Insurance Company
Credit Insurance Division
ATTN: Claims Department
P. O. Box 696785
San Antonio, Texas 78269-6785

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

FRAUD WARNINGS/STATEMENTS

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, 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION, P. O. BOX 696785 * SAN ANTONIO, TEXAS 78269-6785
800-899-6502

CLAIM FORM FOR CREDIT LIFE BENEFITS

1. This form must be completed by the spouse or next of kin.
2. Attach an original death certificate or have an original copied and notarized.
3. Attach a copy of the insurance policy and a copy of the retail installment contract (also known as a note).
4. Attach a copy of your payment history from your creditor.
5. Attach a copy of the letter of testamentary or probated will showing the name of the estate administrator, if possible.
6. **Please mail the above information to our address. We cannot accept a FAX copy.**

SECTION 1

Principal Insured's Name _____ Social Security #_____

Joint Insured's Name _____ Social Security # _____

Name of Deceased _____ Principal ☐ Joint ☐ Policy/Certificate No. _____

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

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

Loan/Account No. _____ Loan payoff amount as of date of death: $_____

Name of Creditor _____ Creditor Phone No. _____

Creditor Address _____

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

SECTION 2 – The following portions **MUST BE COMPLETED** and signed by the surviving spouse, or if none, by the next of kin. **FAILURE TO COMPLETE AND SIGN MAY DELAY YOUR CLAIM.**

Date of Death _____ Cause of Death _____ Occupation _____

If death occurred in a hospital, please indicate the name of the hospital _____

Hospital Address _____ City/State/Zip _____

Other hospital(s), or medical facilities responsible for treatment _____

Facility Address _____ City/State/Zip _____

SECTION 3 – List the family physician and any other physician that treated the deceased during the past 5 years. If additional space is needed, you may attach an additional paper to this form.

Family Physician _____Address_____ Phone _____

Physician _____Address_____ Phone _____

Physician _____Address_____Phone _____

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

Beneficiary/Next of Kin_____ Date _____

Address _____ Phone No. _____

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION
P. O. BOX 696785 * SAN ANTONIO, TEXAS 78269-6785
800-899-6502

CLAIM FORM FOR CREDIT LIFE BENEFITS

NEXT OF KIN AUTHORIZATION

To Whom It May Concern: You are authorized to permit American National Insurance 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 _____. 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
4. Pharmacy prescriptions

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 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 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.

Signed by Next of Kin X _____ this____ day of _____, _____

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

Please Print Next of Kin's Name: _____Phone Number _____

Please Print Next of Kin's Address:_____
Street City State Zip

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION
P. O. BOX 696785 * SAN ANTONIO, TEXAS 78269-6785
800-899-6502

Statement of Medical History

Insured: _____ Claim No._____

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. Please use the reverse side of this form for additional names.

PRIMARY CARE PHYSICIAN:

Name _____ Address _____
(Street)

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

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

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

Dates of Service (From) _____ (To) _____

OTHER PHYSICIANS and/or HOSPITALS:

Name _____ Address _____
(Street)

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

Dates of Service (From) _____ (To) _____

Statement of Medical History - Continued

PHARMACY: _____ Address _____
(Street)

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

PHARMACY: _____ Address _____
(Street)

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

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION
P. O. BOX 696785 * SAN ANTONIO, TEXAS 78269-6785
800-899-6502

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

( ) 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 my medical history/treatment and any past or present employment status.

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

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

_____ _____

Please sign your name Date

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

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION
P. O. BOX 696785* SAN ANTONIO TEXAS* 78269-6785
800-899-6502

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

TO THE INSURED: During your claim and as a part of the claim proof requirements of your policy, Servco Life Insurance Company, and its administrator, American National Insurance Company (the Company), will need information to determine your 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 your claim. Any alteration to or limitation of this Authorization will prejudice the Company's right to independently evaluate your claim and may prevent benefits from being provided.

I AUTHORIZE THESE PERSONS OR ENTITIES having any knowledge of my health or me:
Physician, therapist, healer, or medical practitioner, hospital, clinic, pharmacy, 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: my 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 me including my 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 me, including information concerning my education, occupation, employment history, earnings, finances, unemployment benefits, applications for insurance, or eligibility for other benefits
- Social Security information concerning me, including detailed information regarding earnings for up to ten 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 I have made to restrict my protected health information do not apply to this authorization, and I instruct the persons or organizations identified in paragraph two (2) above to release and disclose my entire medical record without restriction. **Purpose**: The Company will use the information to (1) properly evaluate my claim and determine my 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 me. The Company may release this information about me 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 Company, Credit Insurance Division at P.O. Box 696785, San Antonio, Texas 78269, except to the extent it has been relied upon to disclose requested records. **Expiration**: This authorization will remain in effect for a maximum of 12 months from the date of signature below. **Copy**: My authorized representative or I 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 my complete medical records, my insurance company may not be able to process benefit payments requested under my 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 INSURED OR PERSONAL REPRESENTATIVE	DATE	IF REPRESENTATIVE, GIVE RELATIONSHIP

PRINT NAME OF INSURED	DATE OF BIRTH	SOCIAL SECURITY NUMBER

POLICY/CERTIFICATE NUMBER