

Instructions for Completing Life Claim Form

We are sorry to hear of your loss. Please assist us in preventing unnecessary delays in processing your claim by observing the following instructions when completing the form.

1. Please complete both sides of the form. It should be completed and signed by the deceased's next of kin or the executor of the estate. Please ensure all names and addresses of physicians/medical facilities that treated the deceased are listed on this form. This is to include family physicians.
2. Please provide us with a "CERTIFIED" copy of the death certificate. We cannot process the claim with a notarized or photocopy of the death certificate.
3. Please attach a copy of the certificate of insurance to the completed claim form.
4. Please sign the attached "Release of Information Authorization" which is required to comply with privacy laws and allows us to obtain the information needed to process your claim. Please do not list any specific entities, as we will add that information after determining what information, if any, is needed.

Please mail completed claim form to: Enterprise Life Insurance Company
P.O. Box 167667
Irving, Texas 75016-7667

Upon receipt of this information, your claim will be given our immediate attention. It may be necessary for us to conduct a routine investigation to obtain additional information that will assist us in evaluating your claim. In the meantime, you should notify the lien holder that you would be submitting a claim.

If you have any questions or need additional information, please contact our credit claims department at (800) 527-1984, Ext. #8702.

Sincerely,
Credit Claims Department

ENTERPRISE LIFE INSURANCE COMPANY/UNION SECURITY LIFE INSURANCE COMPANY

P.O. BOX 167667 IRVING, TEXAS 75016-7667
972-445-8300, ext. #8702 OR 800-527-1984, ext. #8702

CLAIM FOR DEATH BENEFIT

CLAIMANT'S STATEMENT

NAME OF DECEASED	DATE OF DEATH
OCCUPATION	CAUSE OF DEATH
EMPLOYER	WHEN DID HEALTH OF DECEASED FIRST BECOME IMPAIRED?
DATE OF BIRTH	ON WHAT DATE DID DECEASED LAST ATTEND TO USUAL WORK?
PLACE OF BIRTH	SOCIAL SECURITY NUMBER

MEDICAL INSURANCE CARRIER (Name)
(Address and Phone #)

LIST ALL PHYSICIANS, CLINICS, OR HOSPITALS THAT TREATED OR PRESCRIBED MEDICATION FOR THE DECEASED WITHIN THE LAST THREE YEARS.

NAME	NAME	NAME
COMPLETE MAILING ADDRESS	COMPLETE MAILING ADDRESS	COMPLETE MAILING ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
DATE: _____	DATE: _____	DATE: _____
CONDITION: _____	CONDITION: _____	CONDITION: _____
PHONE #: _____	PHONE #: _____	PHONE #: _____

NAME	NAME	NAME
COMPLETE MAILING ADDRESS	COMPLETE MAILING ADDRESS	COMPLETE MAILING ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
DATE: _____	DATE: _____	DATE: _____
CONDITION: _____	CONDITION: _____	CONDITION: _____
PHONE #: _____	PHONE #: _____	PHONE #: _____

The undersigned hereby makes claim to said insurance and agrees that the written statements and affidavits of all physicians who have attended or treated the insured and all other proofs of claim shall constitute and they are hereby made a part of these proofs of Death.

AUTHORIZATION: The undersigned hereby authorizes any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, group policy holder, government authority, financial institution, or any past or present employer, to furnish Enterprise Life Insurance Company/Union Security Life Insurance Company or their representatives, any information related to the deceased's health, medical history, diagnosis, treatment, employment, or financial condition, for the purpose of determining insurability or to process a claim for benefits. The undersigned further authorizes the release of any such information to insurance companies, medical facilities, employers, or other entities as necessary to determine insurability or process a claim for benefits. The information authorized for release may include information that could be considered information about communicable or venereal diseases, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, alcohol or chemical dependency, mental or nervous disorders, the human immunodeficiency virus, and acquired immunodeficiency syndrome. The undersigned understands that he/she has the right to receive a copy of this authorization. A photocopy of this authorization shall be as valid as an original, and this authorization shall remain valid for two years from the date of the signature.

CLAIMANT'S SIGNATURE _____ DATE _____ D.O.B. _____ RELATIONSHIP TO DECEASED/EXECUTOR _____

CLAIMANT'S PRINTED NAME: _____ CLAIMANT'S PHONE NUMBER: _____

CLAIMANT'S COMPLETE ADDRESS: _____

EL-2 Rev. (09/02) EL-330 Street City State Zip

LIENHOLDER'S INFORMATION

Name Of Deceased: _____ SS #: _____

Name Of Bank Or Financial Institution _____

Address To Mail Payments _____

City, State, Zip _____ Phone Number: _____

Auto Loan # _____ Monthly Payment Amount: \$ _____

Year, Make & Model _____

Vehicle Identification Number (VIN) _____

This Form To Be Submitted With:

- 1. Certified Copy Of Death Certificate**
- 2. Copy Of Insurance Certificate**
- 3. Copy Of Financial Contract**
- 4. Copy Of The Executor Of The Will**

ENTERPRISE LIFE INSURANCE COMPANY

RELEASE OF INFORMATION AUTHORIZATION

Insured: _____

SSN: _____ **DOB:** _____

I authorize any physician, hospital, insurance company, employer, contractor, financial or educational institution, and/or any specific entities indicated, to release any information regarding medical history, financial condition, education or employment history to Enterprise Life Insurance Company ("ELIC") or Union Security Life Insurance Company ("USLIC").

SPECIFIC ENTITIES (if known): _____

The medical information I authorize for release includes the following: medical history & physical, admission & registration, consultation & evaluation reports, doctor's orders & progress notes, laboratory/pathology reports, radiology/x-ray reports, operative/procedure reports, emergency room records and discharge summaries. The information I authorize for release may include information regarding mental health or illness, chemical or alcohol dependency, and sexually transmitted, communicable or venereal diseases which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

I understand that any of the above information requested by ELIC/USLIC will be used for the purpose of evaluating eligibility for insurance coverage and any claims for life or disability benefits made on behalf of the insured. I understand that once the above information is provided to ELIC/USLIC, it may be re-disclosed and may not be protected by federal privacy laws or regulations. I understand that it is ELIC/USLIC's policy not to release any information to third parties for any reason other than to evaluate eligibility for insurance or a claim for benefits.

I understand that authorizing the disclosure of information is voluntary and I can refuse to sign this authorization; however, I also understand that a refusal may result in ELIC/USLIC being unable to determine eligibility for coverage or benefits. I also understand that, as set forth in the HIPAA Privacy rules (45 CFR 164), my healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present the written revocation to ELIC/USLIC. I understand that the revocation will not apply to an insurance company when the law provides the insurer with the right to contest a claim under the policy or to the extent that action has already been taken in reliance upon the authorization.

The information that I authorize for release shall include information up to 5 years prior to the date of my signature on this authorization, unless otherwise specified.

I also understand that this authorization will expire 5 years after the date of my signature, unless otherwise revoked. A photocopy of this authorization shall be as valid as the original.

DATE: _____ **SIGNATURE:** _____

RELATIONSHIP TO INSURED: _____