NATIONAL FAMILY CARE LIFE INSURANCE COMPANY

P.O. BOX 809043 DALLAS, TEXAS 75380 (972) 387-8553

PRINT FORM TO COMPLETE

CLAIM FORM - LIFE

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(The furnishing of this blank form or the preparation of proofs is not an acknowledgement of liability or waiver of the Company's rights.)

1. IDENTIFICATION

List all NFCL Policy #s

a. Name of Deceased:________________ Date of Birth:__________ Date of Death: __________

b. Beneficiary Relation to Deceased: ________________

c. Address of Deceased: (Street) ________ (City) ________ (State) ________ (Zip) ________

d. Address of Beneficiary: (Street) ________ (City) ________ (State) ________ (Zip) ________

e. Deceased Social Security No.: ________________ Beneficiary Phone No.: ________________

2. CAUSE OF DEATH

a. Illness: □ Yes □ No If Yes, Date of first Symptoms: ________________

b. Accident: □ Yes □ No

c. Police Report Filed: □ Yes □ No If Yes, list name of Police Department and full Address below:

____

d. Has Deceased had this or similar illness before? □ Yes □ No If Yes, when?

3. DOCTORS INFORMATION

a. Date Doctor first consulted for this condition?

	Name	Address	Date	Zip
b. Names and Addresses of the Personal and Attending Physician:	•			
	•			
	•			

	Name	Address	Date	Zip
c. Name and Address of Doctor who made last Electrocardiogram:				

4. HOSPITAL INFORMATION

LIST ALL HOSPITAL CONFINEMENTS FOR TREATMENT OF THIS CONDITION:

Hospital Name: ________________ **Date Admitted:**__________

Address: **(Street)** ________ **(City)** ________ **(ST)** ________ **Date Released:**__________

Hospital Name: ________________ **Date Admitted:**__________

Address: **(Street)** ________ **(City)** ________ **(ST)** ________ **Date Released:**__________

5. TREATMENT INFORMATION

a. Describe kinds of treatment the Deceased received (Medical and/or Surgical) with Dates:

b. List names of any Drugs taken in the last 2 years and supply Dates first taken:

6. COMMENTS

IMPORTANT: Every question must be fully answered. Use a separate sheet of paper if additional space is needed. Send this form to NFCL as soon as possible.

Signed this __________ day of __________, 20______ Beneficiary/Owner ________________

(or Parent if under age 15)

Permanent mailing address of Premium Payor: ________________

Business Phone: ________________ Cell Phone: ________________ Home Phone: ________________

Area Code & Number | Area Code & Number | Area Code & Number

V.A. Claim No. ________________ Military Serial No. ________________

LIFE Claims require the completion of this **CLAIM FORM** and the attached **Medical Release Authorization Form** (for HIPPA Compliance). In addition, a **Certified Death Certificate** must be submitted.

AUTHORIZATION STATEMENT

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, Institution or person that has any records or knowledge of me or my past or present health to give to National Family Care Life Insurance Company, Texas, any such information that they desire. I hereby waive all provisions of law forbidding the disclosure of such information. (To facilitate rapid submission of such information, I authorize all said sources, to include but not limited to Retail Credit Company, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information.) A photographic copy of the authorization shall be valid as the original.

________________ Beneficiary/Owner Signature

________________ Date

Form 2XXCF 4-86 / 2-14