PLATEAU INSURANCE COMPANY

P. O. Box 7001 Crossville, Tennessee 38557-7001 (931) 484-8411
Claims Department Fax No: 931-459-3113 Email: Plateau.claims@plateaugroup.com

ADMINISTRATOR FOR: GUARANTEE TRUST LIFE INSURANCE COMPANY - INDIVIDUAL ASSURANCE COMPANY
KENTUCKY HOME LIFE INSURANCE COMPANY - INVESTORS HERITAGE LIFE INSURANCE COMPANY
MINNESOTA LIFE INSURANCE COMPANY - A SECURIAN COMPANY

REPORT OF DEATH CLAIM

INSTRUCTIONS:
1. COMPLETE SECTION A OF THE FORM.
2. COMPLETE SECTION B AND ATTACH PAPERS NOTED.
3. PLEASE HAVE NEXT OF KIN SIGN AND DATE HIPPA AUTHORIZATION AND PROVIDE REQUESTED MEDICAL INFORMATION ON BACK OF CLAIM FORM.
4. MAIL TO PLATEAU.

SECTION A	PLEASE PRINT OR TYPE	
1. FULL NAME OF DECEASED	LOAN NUMBER	1ST PAYMENT DUE DATE
2. CERTIFICATE NUMBER	3. AGENT / GROUP NO.	4. NAME OF AGENT / GROUP

5. NET PAYOFF BALANCE OF LOAN: $_____

(Amount needed to pay loan off – if your system is showing a refund for life premium, please **add** it back to your payoff.)

PAYOFF GOOD THROUGH (Date) PER DIEM

SECTION B	PLEASE PRINT OR TYPE

6. NAME AND ADDRESS OF SECOND BENEFICIARY (As designated on the original certificate)

7. CREDITOR'S NAME

8. CREDITOR'S ADDRESS (STREET/CITY/STATE/ZIP)

9. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE.

BY: _____

SIGNATURE OF CREDITOR / AGENT PRINTED NAME TITLE

DATE: TELEPHONE NUMBER: EMAIL ADDRESS:

THE FOLLOWING PAPERS MUST BE ATTACHED:
1. CERTIFIED COPY OF THE DEATH CERTIFICATE
2. COPY OF NOTE
3. COPY OF CERTIFICATE OF INSURANCE
4. PAYOFF PRINT SCREEN
5. PAYMENT HISTORY (FOR OUTSTANDING BALANCE CLAIMS, THE HISTORY SHOULD INCLUDE ANY/ALL ADVANCES, THE DATES OF EACH ADVANCE AND THE AMOUNT OF EACH ADVANCE.

******Please provide documentation showing executorship if available. This may be required by the physician and/or hospital if medical records are requested.***

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Please provide the following information for _____
(INSURED'S NAME)

PRIMARY CARE PHYSICIAN'S NAME, ADDRESS, PHONE NUMBER:		
PROVIDE NAMES OF PHYSICIANS OR SPECIALISTS WHO PROVIDED CARE IN THE PAST 3 YEARS :		
NAME	ADDRESS	PHONE NO.

This Authorization was prepared by Plateau Insurance Company for purposes of obtaining information necessary to process a claim for benefits. CERTIFICATE : _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), ANY licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, pharmacy benefit manager, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide PLATEAU INSURANCE COMPANY or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs, use of alcohol or HIV. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that my health provider may not condition treatment, payment, enrollment in the health plan or eligibility for benefits on my execution of this authorization.

I understand that Plateau Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand that the information disclosed by this authorization could be disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements.

This Authorization is valid from the date signed for the duration of the claim.

_____

(Print please) Name of Patient Date of Birth

_____

Signature of Patient, Authorized Representative, or Next of Kin Date Signed

_____

(Print Please) Name of Authorized Representative, or Next of Kin

_____

Relationship of Authorized Representative or Next of Kin to Patient Phone No: