ALLIED FUNERAL ASSOCIATES INSURANCE COMPANY

316 S. Thomas St., Tupelo, MS 38801
P. O. Box 4080, Tupelo, MS 38803-4080
Telephone (662) 840-9911 Fax (662)840-0911
Toll Free 1-888-674-0297

CLAIM FORM

AUTHORIZATION FOR PAYMENT:

Policy Number	Effective Date	Amount of Insurance
____________________	__________________	___________________
____________________	__________________	___________________

Name of Deceased: ____

Date of Birth: ________________________ **Date of Death:** ____________________

Beneficiary Name: ____

Beneficiary Address: ____
City State Zip

Beneficiary Phone #: Home__________________ **Cell**_____________________

Proceeds to be paid to: ____**for $**______________________________

____
Address City State Zip

If applicable, any proceeds remaining after named Funeral Home is paid, will be paid to beneficiary named other than Funeral Home.

I declare that I am the Beneficiary of the Policy(s) shown above and entitled to release the proceeds. I agree that such payment shall discharge, in full, all liability of the Company under the Policy(s).

X____ _____________________________
Signature of Beneficiary **Date**

Please attach a copy of a Photo ID (Driver License or State Issued ID) of Beneficiary or person/persons signing Claim Form

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION:
(MUST BE COMPLETED IF POLICY HAS BEEN IN FORCE FOR LESS THAN TWO YEARS)

Print name, address and phone number of all Physicians, Hospitals, or other Health Care Providers who treated the deceased.

____
Name Address Phone #

____
Name Address Phone #

To all Physicians, Hospitals, or other Health Care Providers: (NOTE: A copy of this authorization shall be considered as effective and valid as the original.) You are hereby authorized to disclose to Allied Funeral Associates Insurance Company, or its representatives, all information with respect to illness, injury, medical history, consultation, prescriptions, or treatments, and copies of all hospital or medical records of:

____ ____
Name of Deceased **Relationship to Deceased**

____ ____
Signature of Next of Kin/Legal Representative **Date Home Phone # Cell #**