PLATEAU INSURANCE COMPANY

P. O. Box 7001 Crossville, Tennessee 38557-7001 (931) 484-8411
Claims Department Fax No: 931-459-3113

ADMINISTRATOR FOR:
GUARANTEE TRUST LIFE INSURANCE COMPANY – INDIVIDUAL ASSURANCE 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. MAILTO PLATEAU.

Section A	Please Print or Type	
1. FULL NAME OF DECEASED	LOAN NUMBER	1ST PAYMENT DUE DATE
2. CERTIFICATE NUMBER	3. AGENT/ACCOUNT/GROUP NO.	4. NAME OF AGENT/ACCOUNT/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____ TITLE:_____________________
SIGNATURE OF CREDITOR/AGENT - PRINTED NAME

DATE: ___________________ TELEPHONE NUMBER: ______________________________

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.

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Please provide the name, address and telephone number of: _______________________________'s
Primary Care Physician: ______________________________ (Insured's Name)
____
____

Please provide the name, address and telephone number of any other physicians or specialist who provided care for
___________________________ within the past 3 years. Attach additional sheet if necessary.
(Insured's Name)
____
____
____

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

Policy/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, 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 or use of alcohol & HIV. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. 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 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 re-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.

____
Date of Birth

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

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

____
Relationship of Authorized Representative or Next of Kin to Patient