American Century Life Insurance Company
1333 W. McDermott Dr. #200
Allen, TX 75013
Phone (855) 966-1111
Fax (855) 855-0181

Death Claim

WARNING

Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Policy Information

Policy #: Issue Date: / / Amount:

Insured Information

Full Name: Date of Birth: / / SSN:

Address: City: State: Zip:

Date of Death: / / Place of Death: Benefits Amount: $

Beneficiary Information

Full Name: Relationship to insured: Phone #:

Address: City: State: Zip:

SSN: Date of Birth: / /

The undersigned hereby makes claim to said insurance benefits in the American Century Life Insurance Company (the Company) policy.

The undersigned hereby (1) authorizes the Company to request any information concerning the death of the insured that the Company may deem necessary; (2) authorizes any physician or medical institution to provide such information when requested by the Company; and (3) agrees to take any reasonable action required to cause any such information to be released to the Company.

Provide original copy of one document from each group below (check the documents provided):

Group 1:

- ☐ The full original life insurance policy
- ☐ Affidavit of Lost Policy

Group 2:

- ☐ Original death certificate
- ☐ Certified copy of the death certificate

Please send original copies by mail of the claim form and the above documents. Do not fax or email.

Dated at: _____ This _____ day of _____

State of Texas, County of: _____ Signed: _____

Sworn and subscribed before me on this _____ day of _____

_____ Notary My commission expires _____

(Seal)

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Authorization for Release of Medical Records

Authorization for: ☐ Disclosure ☐ Inspection ☐ Amendment of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

I hereby authorize the medical professionals and facilities listed below to release my records from the following facilities (list all facilities from which the insured received medical services from the date of the application for insurance with us):

Dr. Name	Facility Name	Address	Phone
1.			
2.			
3.			
4.			

Release to: (please provide names/address of persons/organization to which disclosure is to be made)
American Century Life Insurance Company
1333 W. McDermott Dr. #200
Allen, TX 75093
Phone: (855) 966-1111, Fax: (855) 855-0181

Date of Service to be released: _____

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance

Select Portions of Protected Health Information authorized to release

☐ Abstract/Pertinent Information ☐ Lab ☐ Emergency Room ☐ MD Progress Notes
☐ Cardiac Studies ☐ H & P ☐ Consultation Report ☐ Face Sheet
☐ Operative/Procedure Report ☐ CPT Codes ☐ Itemized Bill ☐ Radiology
☐ Admit/Discharge Summary ☐ Radiology Reports ☐ Digital Images
☐ Other: _____
☐ ENTIRE RECORD
EXCLUSIONS: _____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of the Doctors' offices and facilities listed above to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

Date	Signature of Patient/Parent/Conservator/Guardian	Authority/Relationship to Patient

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Affidavit of Next of Kin

The undersigned, being first duly sworn, deposes and says:

1. That I am the next of kin of _____, who died on or about the _____ day of _____, 20_____.
2. That my relationship to the deceased is _____.
3. That no personal representative has been appointed for the decedent's estate in this state or elsewhere and no application for such appointment is pending in this state or elsewhere.
4. That this affidavit is made in support of the request for release of medical records of the deceased.
5. That the undersigned agrees and understands that, pursuant to Federal law, American Century Life Insurance Company ("ACLIC") will not release copies of the medical records of the deceased to the undersigned.
6. I present this affidavit to ACLIC to evidence my authority to act in such capacity as surviving next of kin; and, in consideration of ACLIC to agreeing to act in reliance thereon, I agree to indemnify and hold harmless the ACLIC party or parties to whom this is presented, as well as their directors, officers, employees, and agents from any and all damages or losses, including costs of court and attorney fees, occasioned by reliance on this information.

The foregoing is the truth to the best of my knowledge, information, and belief. Dated at:

_____ _____ This _____ Day of _____ , 20_____
(City) (State)

_____
Signature

_____
Print Name

_____ _____ _____ _____
Address City State Zip Code

_____
Telephone

Sworn and subscribed before me, on _____

Notary Public _____

My commission expires on _____