

American Century Life Insurance Company of Texas

(a stipulated premium company) 1333 W. McDermott Dr., Suite 150 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: S			nt: \$				
Beneficiary Information								
Full Name:	Relationship to	insurec	l:	Phone #	t:			
Address:	City:			State:	Zip:			
SSN: Date	of Birth: /	/						
The undersigned hereby makes claim to said insurance benefits in the American Century Life Insurance Company of Texas (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:	Group 2	<u>):</u>						
				ath certificate				
Affidavit of Lost Policy	C	ertified	copy of th	ne death certificate	2			
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:	Signe	d:						
Sworn and subscribed before me on this		commi	ssion expi	res				

(Seal)

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Authorization for Release of Medical Records

Authorization for:	X Disclosure	Inspection	Amendme	nt of Protected Health	Information
Patient Name:				Date of Birth:	
Address:				Telephone:	
I hereby authorize the n facilities (list all facilities insurance with us):					
Dr. Name	Facility Nam	ie	,	Address	Phone
1.					
2.					
3.					
4.					
Release to: (please prov American Century Life In 1333 W. McDermott Dr. Allen, TX 75093 Phone: (855) 966-1111,	nsurance Compa ., Suite 150	iny of Texas	nganization t	o wnich disclosure is to	o be made)
Date of Service to be rel	eased:				
For the following purpor	se: Medic	al Care Lega	ıl X Insur	ance	
Select Portions of Prote	cted Health Info	ormation author	ized to relea:	se	
Abstract/Pertinent I	nformation	Lab	E	mergency Room	MD Progress Notes
Cardiac Studies		H & P	C	onsultation Report	Face Sheet
Operative/Procedure	e Report	CPT Codes	It	emized Bill	Radiology
Admit/Discharge Sur	mmary	Radiology Repo	orts D	igital Images	
Other:					
ENTIRE RECORD					
EXCLUSIONS:					
This authorization is a not to exceed 24 morabove.					
I, the undersigned, have to disclose such informa time except to the exter is used or disclosed purs longer be protected. I he liability and damages re	ation as herein cont that action ha suant to this autle ereby release an	ontained. I have s been taken in r horization, it ma Id hold harmless	the right to r eliance upon y be subject t the above na	evoke this authorization it. I understand that we concert it or e-disclosure by the samed facility and its pa	on in writing at any when this information recipient and may no irent company from all
Date	Signature of Pa	tient/Parent/Conse	rvator/Guardian	Authority/	Relationship to Patient

American Century

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

American Century Life Insurance Company of Texas

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Affidavit of Next of Kin

1.	That I am the next of kin of _			, wh	no died on or about			
	the day o	f		, 20	·			
2.								
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 of Texas ("ACLIC") will not release copies of the medical records of the							
	deceased to the undersigned.							
6.	•							
	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 court and attorney fees, occasioned by reliance on this information.								
	court and attorney rees, occ	asioned by ren	ance on this inic	iiiiatioii.				
The fo	regoing is the truth to the bes	t of my knowle	edge, information	n, and belief. Dat	ed at:			
		Thic	Day of		20			
	(City) (State)	11115	Day 01 _		, 20			
	, ,, , , , , , , , , , , , , , , , , ,							
Signa	ture							
J.B.I.G								
Drint	Name							
PIIII	Name							
Addr	ess		City	State	Zip Code			
Telep	hone							
Swor	n and subscribed before me, c	n						
	Notary Public							
	My commission expires of	on						
	,							