1010 ALL CAUSE DEATH BENEFIT ACTIVATION FORM

COMPLETE FIELDS #1 THROUGH #5 ON THE SECOND PAGE OF THE FORM

PRINT THE FORM AFTER COMPLETING PAGE TWO

SIGN, DATE, AND FILL IN RELATIONSHIP AT THE BOTTOM OF PAGE TWO

PAGE ONE NEEDS TO BE COMPLETED BY THE LENDING INSTITUTION

ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE

RETURN PAGES ONE AND TWO ALONG WITH THE DEATH CERTIFICATE TO:

PEKIN LIFE INSURANCE COMPANY
ATTN: FINANCIAL PRODUCTS BENEFITS DEPT.
2505 COURT STREET
PEKIN IL 61558

309-346-1161, x2329

Reset

NOTICE OF DEATH PROTECTION BENEFITS

NAME OF CREDITOR

ADDRESS

CITY STATE ZIP

CUSTOMER/LOAN NUMBER LOAN EFFECTIVE DATE

AGENT CODE

INSTRUCTIONS

1. Complete this form as soon as possible after death of Borrower.
2. Have nearest next of kin complete second page, sign authorization and return to you.
3. When this form is fully completed, attach:
   (a) Certified copy of Death Certificate
   (b) Copy of Loan Contract
   (c) If MOB, Copy of Ledger Sheet, Note, Authorization Card

PEKIN LIFE INSURANCE COMPANY

FINANCIAL PRODUCTS DEPARTMENT
2505 COURT STREET, PEKIN, ILLINOIS 61558

PROOF OF DEATH – STATEMENT

Full Name of Deceased _____ Date of Birth _____

Address _____ Date of Death _____

City _____ State _____ Zip _____ Last 4 Digits of Soc. Sec. of Deceased _____

Loan Number	Date of Addendum	Original Term	Initial Amount of Loan	Minus Reduction Amount	= Benefit Amount
			$	$	$
			$	$	$
			$	$	$

TOTAL $ 0.00

Loan payoff amount as of date of death $ _____

I hereby certify that the answers given above are full and true:

_____ _____
NAME OF FINANCIAL INSTITUTION ON ADDENDUM ADDRESS CITY & STATE

_____ _____
SIGNATURE TITLE

_____
DATE

Subscribed and sworn to before me this _____ day of _____ , 20 _____

_____
SIGNATURE AND SEAL OF NOTARY OR JUSTICE

CL 1010 (11-07)

PEKIN LIFE INSURANCE COMPANY
2505 Court Street
Pekin, IL 61558

Indiana Claims: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Ohio Claims: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

TO BE COMPLETED BY THE NEAREST NEXT OF KIN:

1. Deceased's Name: _____ Last 4 Digits of Social Security # _____

   Please list any other names by which insured may have been known. _____

   _____

   (Include maiden name, hyphenated name, nickname, derivative form of first and/or middle name, or alias.)

   Date of Birth _____ Occupation at Death _____ Date Last Worked _____

2. When did deceased first complain or give other indications of this illness? _____

3. When did deceased first consult a physician for this illness? _____

4. Names and addresses of all physicians who treated the deceased within five years preceding death:

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

5. Names and addresses of all hospitals where deceased was confined:

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

   Name _____ Street, City, State _____

   Dates of Treatment _____ Disease or Condition _____

I hereby certify that the answers given above are full and true:

DATE _____ **Relationship to Deceased** _____ _____
(Signature)