

1019 HOSPITALIZATION BENEFIT ACTIVATION

FILL OUT PART ONE, BE SURE TO COMPLETE FIELDS #1 THROUGH #17 c

PRINT THE FORM AFTER COMPLETING THE ABOVE INDICATED FIELDS

SIGN AND DATE PAGE ONE

HAVE PAGE TWO COMPLETED BY YOUR PHYSICIAN

RETURN BOTH PAGES TO:

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

309-346-1161, x2329

Hospitalization Benefits Activation Form

FINANCIAL INSTITUTION – COMPLETE THIS SECTION BEFORE GIVING FORM TO PROTECTED BORROWER

Name of Insured in full _____

Customer ID number _____ Term of Loan _____ Loan Date _____

Creditor _____ Agent # _____

Completed by _____ Title _____ Date _____ Phone _____

Please complete all fields. Missing information may cause processing delays.

Part 1 – To be completed by Protected Borrower

1. Customer ID Number		2. Last 4 Digits of Social Security Number		3. Date of Birth	
4. Last Name			5. First Name		6. Middle Initial
7. Address			8. City		8a. State 8b. Zip
9. Phone Number		10. Has your loan been refinanced? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide prior loan number.			
11. Diagnosis/Condition you were hospitalized for?					
12. Dates Hospitalized: _____ to _____		13. Name & Phone Number of Hospital _____			
14. Attending Physician's Name					
15. Attending Physician's Phone Number (Required)			16. Attending Physician's Fax Number		
17. Attending Physician's Street Address (Required)		17a. City		17b. State	17c. Zip

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

Signature

Date

Please Complete Page 2

**Return completed forms to:
Pekin Life Insurance Company, Financial Products Benefit Activation, 2505 Court Street, Pekin, IL 61558.**

Hospitalization Benefits Activation Form – Page 2

Please complete all fields. Missing information may cause processing delays.

Part 2 – To be completed by Physician

18. Diagnosis and Concurrent Condition		19. Was hospitalization due to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Was patient hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Name of Hospital		
22. Hospital admission date (mo-day-yr)		23. Hospital release date (mo-day-yr)	
24. Attending Physician's Printed Name		25. Street Address	
26. City		27. State	28. Zip Code
29. Phone Number (Required)		30. Fax Number (Required)	
31. Attending Physician's Signature			32. Date

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