SURETY CAPITAL CORPORATION

Date

FAX

FAX #: **817-984-8809**

Phone: 817-850-9800

Company Name: Surety Capital Corporation

From:

Phone:

Company Name:

Fax:

Number of Pages:

6145 WEDGWOOD DR., FORT WORTH, TEXAS 76133, 817-850-9800 VOICE/817-984-8809 FAX

SURETY CAPITAL CORPORATION

VERIFICATION FORM

DATE _____ FUNERAL HOME _____

DECEASED _____SS#_____

DATE OF DEATH _____ DATE OF BIRTH _____

PLACE OF DEATH _____

CAUSE OF DEATH (IF KNOWN) _____

INSURED, IF DIFFERENT THAN DECEASED: _____

INSURANCE POLICY (IES) NUMBER(S): _____

AMOUNT OF THE ASSIGNMENT: _____

INSURANCE COMPANY _____

ADDRESS _____

_____

INSURANCE COMPANY'S TELEPHONE NUMBER _____

GROUP (EMPLOYER) _____

ADDRESS _____

_____

GROUP TELEPHONE NUMBER _____

BENEFICIARY _____

RELATIONSHIP TO INSURED _____

IF BENE DECEASED:

DATE OF DEATH _____

DATE OF BIRTH _____

PLACE OF DEATH _____

6145 WEDGWOOD DR., FORT WORTH, TEXAS 76133, 817-294-8888 VOICE/817-984-8809 FAX

SURETY CAPITAL CORPORATION

IRREVOCABLE ASSIGNMENT & REASSIGNMENT ("IA")
& Limited Durable Power of Attorney ("POA")

INSURED: _____

INSURANCE COMPANY, BUSINESS OR GOVERNMENT ENTITY (hereinafter referred to as "ICBG"): _____

_____

INSURANCE POLICY, PLAN, ANNUITY, CLAIM or BENEFIT NUMBER(S) (hereinafter referred to as "Policy"): _____

_____

FOR VALUE RECEIVED the undersigned person(s) equitably or legally entitled to the benefits, now or in the future, under the above mentioned or described Policy hereby irrevocably assigns, sets over, conveys, transfers and or sells to _____(hereinafter referred to as "FH")

6145 WEDGWOOD DR, FORT WORTH, TX 76133, its successors and assigns the sum of $ _____ **plus statutory and/or contractual interest** from the date of death and all premiums which are to be paid from the benefits, proceeds, premium(s) and interest of the above-mentioned or described Policy or any life insurance benefit of the undersigned person(s) connected to Insured. In addition, the undersigned person(s) assigns all of my/our claims & causes of action connected with the Policy including, but not limited to, all benefit & non-benefit ERISA claims.[1] The undersigned person(s) hereby irrevocably authorizes the above-named ICBG to make payment of the sum specified herein to the FH's Assigns on its order. The consideration for this IA is the FH rendering funeral services or assisting with the disposition of remains of the above-named Insured which services have been specifically ordered and accepted by me/us and/or additional monies advanced to me/us for my/our personal benefit. For valuable consideration, the undersigned FH does hereby irrevocably assign, transfer, convey and/or sell to **SURETY CAPITAL CORPORATION** ("SRYP") its successors and assigns all of FH's right, title and interest in the IA, and the insurance proceeds and Policy benefits and causes of action therein referred to, and do hereby direct that payment be made to SRYP hereby ratifying, confirming and approving anything that the said SRYP may do by virtue of the authority and direction given herein. In addition, the undersigned FH assigns the right to collect from person(s) who is/are liable for INSURED's funeral or cemetery expenses. **TIME IS OF THE ESSENCE, the undersigned person(s) hereby irrevocably authorizes and directs insurance company, third party administrator, record keeper or any business or government entity to give FH & SRYP any confidential, medical or Policy information that SRYP and/or FH require regarding Decedent, Beneficiary(ies) and said Policy by email, fax or phone to HELP THE FAMILY SECURE TIMELY ARRANGEMENTS FOR INSURED'S FUNERAL and/or BURIAL and to ensure proper payment of Policy benefits.** The undersigned person(s) authorizes disclosure of Protected Health Information Pursuant to HIPAA 45 C. F. R. 164.512 to SRYP. The undersigned person(s) and FH hereby irrevocably appoint SRYP or its Assigns as my/our Attorney-in-Fact to act for me/us with full power to make collection of, compromise, settle and receipt for the proceeds of said Policy in my/our names or otherwise with authority to: endorse checks and benefit forms in my/our individual, estate representative, trustee or FH capacity; receive & complete claim forms or packets; receive information concerning Insured's above-mentioned or described Policy; obtain plan documents; receive medical or confidential information pursuant to HIPAA, ERISA and/or FOIA; add, redo or amend this IA; order death certificates of Insured; insert my/our signature on claim, assignment or benefit forms as fully as I/we myself/ourselves could do, with full power of substitution and revocation hereby ratifying and confirming all that my/our attorneys or their substitutes may do or cause to be done by virtue of the authority and direction given herein even if undersigned subsequently becomes incapacitated. In the event that any payment is made to me/us for the Policy subsequent to the execution of this IA, such proceeds shall be delivered in the original form received to SRYP or its Assigns; such proceeds will not be commingled with any of our other funds or property but will be held separate and apart therefrom and upon an express trust until delivery thereof is made to SRYP or its Assigns. The undersigned person(s) & FH hereby expressly consent and agree to personally submit to the jurisdiction of all levels of any and all State and Federal Courts located in Tarrant County, the State of Texas, arising out of any and all litigation which occurs as a result of any dispute regarding this IA, POA or Policy. The substantive law of the state where Insured died will be used to enforce IA against ICBG. I/we agree to pay all costs, expenses, and reasonable attorney's fees incurred in enforcing any of the covenants and provisions of this IA and incurred in any action brought against me/us on account of the provisions hereof. The undersigned & FH attests that the information in this IA is accurate. **SRYP promises non-recourse** if there is no fraud or misrepresentation of any information given to SRYP. Otherwise, on demand, the undersigned & FH promise to pay to the order of SRYP $_____with interest at the highest permissible rate allowed under Texas Statutes until paid. I/We warrant and represent individually, jointly, and severally that I/We have not heretofore assigned any of the proceeds of the Policy to any person(s) or entity(ies) whatsoever. Notwithstanding, I/We hereby revoke any and all other prior assignments made by me/us of the proceeds of the above captioned Policy to any person(s) or entity(ies) whatsoever prior to the date below and attest this IA take precedence over any assignment of the proceeds of the above captioned Policy. In the event that any payment is made to SRYP for the above-mentioned Policy that is in excess of the assigned total, the undersigned person(s) & FH hereby agree that SRYP, its successors or assigns, will take possession of the excess amount for itself until such time as the undersigned person(s) and/or FH agree in writing to its distribution. If the undersigned & FH do not agree in writing within one year after receipt of the excess funds, the excess funds belong solely to SRYP. **If the Policy is not included with the claim, after a diligent search, I/we attest the Policy is LOST. The undersigned person(s) and FH attest the Insured is dead. I/we attest that a copy of this IA and POA is intended to be treated as if it were the original.** In the event any covenants and provisions are determined invalid, all other covenants and provisions will remain intact & enforceable. I (We) agree that the signature below is an electronic signature and shall be applied to this IA and all forms mentioned above completed by my/our limited POA. IN WITNESS WHEREOF, WE HAVE HEREUNTO SET OUR HANDS AND SEALS **THIS** ____ **DAY OF** _____**, 20**____**.**

→ _____ → _____

BENEFICIARY'S SIGNATURE & RELATIONSHIP **BENEFICIARY'S SIGNATURE & RELATIONSHIP**

Beneficiary Name	Your relationship to the Deceased?	Address (Street, City, State, Zip)	Birthdate	Social Security #
	☐Spouse ☐Child ☐Sibling ☐Other: _____			
	☐Spouse ☐Child ☐Sibling ☐Other: _____			

→ _____ _____

FUNERAL DIRECTOR'S / CEMETERIAN'S SIGNATURE **FUNERAL HOME or CEMETERY NAME**

On _____**/**____**/20**____, before me, _____, **a Notary Public**, personally appeared_____, _____,**beneficiary(ies)** and _____, **funeral director(s)** who acknowledge themselves to be the persons whose names are subscribed to the within instrument. IN WITNESS WHEREOF, I hereunto set my hand and official seal.

_____**NOTARY PUBLIC SIGNATURE & STAMP**

1 - Employee Retirement Income Security Act ("ERISA").

SURETY CAPITAL CORPORATION

STANDARD LIFE INSURANCE CLAIM FORM

INSURANCE COMPANY: _____

1. POLICIES UNDER WHICH CLAIM IS BEING MADE:

Policy number	Date of Issue
_____	_____
_____	_____
_____	_____

2. DECEASED: _____ SOC. SECURITY# _____
3. DATE OF DECEASED'S BIRTH: _____ DATE OF DEATH: _____
4. PLACE OF DEATH: _____
5. CAUSE OF DEATH: _____
6. NAME OF CLAIMANT: _____
7. ADDRESS OF CLAIMANT: _____

_____

8. SOCIAL SECURITY NUMBER OF CLAIMANT: _____
9. CLAIMANT'S RELATIONSHIP TO DECEASED: _____
10. CLAIMANT'S DATE OF BIRTH: _____
11. WHY ARE YOU CLAIMING INSURANCE PROCEEDS: BENEFICIARY OF POLICY
12. **CLAIM IS ASSIGNED TO SURETY CAPITAL CORP., 6145 WEDGWOOD DR., FORT WORTH, TX 76133 IN THE AMOUNT OF $_____**
13. OCCUPATION OF DECEASED: SEE DEATH CERTIFICATE
14. NAME OF LAST EMPLOYER: SEE DEATH CERTIFICATE
15. WHEN WAS HEALTH OF DECEASED FIRST AFFECTED: SEE DEATH CERTIFICATE
16. DURATION OF LAST ILLNESS: SEE DEATH CERTIFICATE
17. WAS AN AUTOPSY PERFORMED: SEE DEATH CERTIFICATE
18. WAS CORONER'S INQUEST HELD: _____ (attach copy of the report)
19. NAME AND ADDRESS OF PHYSICIAN(S) CONSULTED DURING LAST ILLNESS:

_____

_____

20. IF POLICY IS LESS THAN TWO YEARS OLD, NAME AND ADDRESSES OF ALL PHYSICIANS CONSULTED DURING THE PAST TWO YEARS:

_____

_____

I hereby certify that the answers to questions set forth above are complete and true to the best of my knowledge and belief.

_____ _____

Witness Signature of the Claimant

AUTHORIZATION TO GIVE OUT INFORMATION

TO WHOM IT MAY CONCERN: Upon presentation of this form, or a photostatic copy thereof which is as valid as the original, you are authorized and directed to disclose to Surety Capital Corporation or its representatives, or to give as evidence in any legal proceeding to which said Company is a party, any records, information, knowledge or belief you may have relating to the employment, membership, health, medical, psychiatric or surgical history, treatment, or hospitalization, or cause of death including any autopsy report pertaining to the named deceased. To facilitate rapid submission of such information, you are authorized to give such records or knowledge to any agency employed by the INSURANCE COMPANY to collect and transmit such information.

DATE: _____ DECEASED: _____

CLAIMANT: _____

RELATIONSHIP: _____

_____ _____

Witness Signature of the Claimant

6145 WEDGWOOD DR., FORT WORTH, TEXAS 76133, 817-294-8888 VOICE/817-984-8809 FAX

SURETY CAPITAL CORPORATION

UNIVERSAL AFFIDAVIT FOR LOST POLICY

I (We), the undersigned, hereby certify and upon oath represent that Policy number_____ issued on the life of _____, insured, on the _____ day of _____, _____, has been lost or destroyed and that said policy is not assigned, hypothecated or pledged except to **Surety Capital Corporation 6145 WEDGWOOD DR., FORT WORTH, TEXAS 76133** in any way whatsoever; that I (we) the undersigned, am (are) the beneficiary under said policy, and that this policy became a claim due to the death of the aforesaid insured, on the _____ day of _____, 20___. It is distinctly understood and agreed that should the original policy be found, it is to be returned to the _____Life Insurance Company its successors or assigns.

I (We) further agree that if any other person should surrender the policy to the INSURANCE COMPANY and make demand for payment therefore from the company claiming to own the policy by virtue of a gift of said policy from the insured to such other persons during the lifetime of the insured and should a Court of Law or Equity Judicially determine that such other person or persons rather that the undersigned is entitled to be paid the proceeds of this policy then in that event, I (we) agree to reimburse said company for the amount so paid to the undersigned.

_____

Beneficiary Signature

_____

Beneficiary Signature

6145 WEDGWOOD DR., FORT WORTH, TEXAS 76133, 817-294-8888 VOICE/817-984-8809 FAX

SURETY CAPITAL CORPORATION

ONE AND THE SAME PERSON AFFIDAVIT

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned authority, a Notary Public in and for the State of _____, on this day personally appeared, known to me, and who, after being by me duly sworn on oath stated:

My name is _____ whose date of birth is _____.

I am and was one and the same person as _____.
I am making this statement under oath in order to induce payment of _____
Life insurance company, Policy Number(s) _____.

Executed on this _____ day of _____ , _____.

AFFIANT:

_____

SUBSCRIBED AND SWORN TO BEFORE ME, on this ____day of _____ , _____.

_____ NOTARY PUBLIC, STATE OF _____

MY COMMISSION EXPIRES : _____

6145 WEDGWOOD DR., FORT WORTH, TEXAS 76133, 817-294-8888 VOICE/817-984-8809 FAX

SURETY CAPITAL CORPORATION

SMALL ESTATE AFFIDAVIT

STATE OF: _____) SS.
COUNTY OF:_____)

_____, residing at _____
(Affiant's Address)

being duly sworn, deposes and says:

_____, insured under policy number(s)_____
(Insured/Deceased)

issued by_____ died on the date of _____
(Insurance Company)

leaving no will, and that no petition for the appointment of an executor or administrator of the decedent's estate has been granted, is pending or contemplated; that all of the bills, debts, expenses, taxes and charges of whatsoever kind or nature of either said decedent or said Decedent's Estate have been paid **except for funeral expenses** in the amount of _____; and that the gross value to the Decedent's real and personal property, excluding exempt property, does not exceed $_____.

The following relatives of the decedent were surviving at the time of the decedent's death:

Relationship	Name	Age	Address

The names of heirs-at-law of the decedent are listed above and there are no others who could claim an interest in the estate.

The undersigned recognizes that the Insurance Company will rely on this Affidavit, agrees to indemnify Insurance Company from any claim of suit (including Attorney's fees) filed arising out of the subject policy, and request said Insurance Company to waive the requirement of administration and honor the instructions attached to the affidavit.

_____
(Signature of Affiant)

_____
(Relationship of the Decedent)

Subscribed and sworn to before me this_____day of_____, 20____.

_____ _____
(SIGNATURE OF NOTARY PUBLIC) (NOTARY STAMP OR SEAL)