

TO GET STARTED: ● **COMPLETE THE IRREVOCABLE ASSIGNMENT and**
 ● **VERIFICATION OF CLAIM AND LIMITED DURABLE POWER OF ATTORNEY**
 ● **FAX BOTH FORMS WHEN SIGNED TO 877-603-8999 or 720-664-6466 OR EMAIL Susan@Istnatl.net**
Call First National at 970-673-8333 to make sure claim is received.

VERIFICATION OF CLAIM AND LIMITED DURABLE POWER OF ATTORNEY

INSURED NAME: _____ **SS#** _____
DATE OF BIRTH: _____ **DATE OF DEATH:** _____
PLACE OF DEATH: ADDRESS: _____ **CITY/STATE:** _____
CAUSE OF DEATH: Natural Homicide Suicide Accident Unknown (detail below)

INSURANCE BENEFIT: TYPE OF INSURANCE COVERAGE? GROUP POLICY? INDIVIDUAL POLICY?
If GROUP INSURANCE, provide Employer (Company Name), a Contact Name, & Phone Number:

INSURANCE COMPANY NAME _____
POLICY (IES) # for this Claim: _____

\$ _____ FUNERAL / CEMETERY BILL ASSIGNMENT WITH CASH ADVANCES

FUNERAL HOME NAME: _____

Beneficiary 1: _____
 Your Social Security #: _____ Date of Birth _____
 Relationship to Deceased: Parent Spouse/Life Partner Grandparent Aunt/Uncle Brother/Sister
 Son/Daughter Other (Explain): _____
 Address (City/State/Zip) & Phone #: _____

Beneficiary 2: _____
 Your Social Security #: _____ Date of Birth _____
 Relationship to Deceased: Parent Spouse/Life Partner Grandparent Aunt/Uncle Brother/Sister
 Son/Daughter Other (Explain): _____
 Address (City/State/Zip) & Phone #: _____

DIRECTIVE and LIMITED DURABLE POWER OF ATTORNEY

TO WHOM IT MAY CONCERN: Upon presentation of this form, or a photo static copy thereof which is as valid as the original, you are authorized and directed to disclose insurance information and produce any documents required to settle any life insurance benefit on the Insured to **First National (“FN”)**¹. The undersigned hereby irrevocably authorizes and directs the insurance company, third party administrator, record keeper or any business or government entity to deal directly with FN to give any information that FN requires regarding Insured, Beneficiaries, and the insurance benefit either orally or in writing by email, fax, phone, text and mail including confidential, personal and medical information to ensure: proper filing for and payment of insurance policy benefits, resolving any denial of insurance policy benefits, and determine the validity of any reason(s) for any delay of payment of insurance policy benefits, and **providing immediate HELP FOR THE FAMILY TO SECURE TIMELY ARRANGEMENTS FOR INSURED’S FUNERAL or BURIAL.** In addition the undersigned principal(s) **individually hereby expressly:** (1) authorize disclosure of Protected Health Information of Insured & Beneficiaries pursuant to HIPAA 45 C. F. R. 164.512 to FN; (2) **irrevocably appoint FN as undersigned principal’s Agent and Attorney-in-Fact** with full power of substitution, to act for me/us with full power and authority to (i) enforce collection of, compromise, assign, settle and give receipt for any benefits & proceeds connected with or related to Insured & Beneficiaries to the extent necessary to fully cover Insured’s funeral cost or assignment amount, (ii) endorse or sign checks, assignments, estate and benefit forms in such undersigned principal’s individual, estate representative, and trustee capacity, (iii) receive and complete any claim, assignment, probate or small estate forms connected with or related to Insured (iv) receive plan documents, insurance, medical and confidential information concerning the Insured & Beneficiary, (v) insert employer, insurer, policy or claim numbers on any assignments of Insured & Beneficiary, (vi) **add policy numbers, redo or amend any assignments of the above Insured & Beneficiary to correct errors, clarify ambiguities, and give further legal effect to the purpose and intent hereof,** (vii) **order death certificates of Insured,** (viii) insert undersigned’s signature on any claim, assignment, small estate, tax, funeral bill, complaint or benefit forms as fully as undersigned principal(s) or Beneficiaries could personally do, (ix) file lawsuits in my/our name due to negligence, bad faith or unpaid interest as a result of payment delay or denial by insurer or employer of Insured’s claim; (3) **ratify and confirm all that my/ our attorney in fact may do or cause to be done by virtue of the authority and direction given herein,** and (4) this power of attorney is not affected by subsequent disability or incapacity of any undersigned principals or beneficiary. The undersigned principal(s) 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 Directive or Limited Durable Power of Attorney and any assignment thereof. The undersigned principal(s) agree a copy of this agency agreement is to be treated as the original and my/our signature is to be used as an electronic signature pursuant to 15 USCS § 7001. **THE UNDERSIGNED PRINCIPAL(S) & BENEFICIARIES AGREE TO HOLD HARMLESS INSURER, ENTITY OR PERSON FROM ALL LIABILITY TO ME/US BY HONORING THIS POWER OF ATTORNEY; PAYING FN’S ASSIGNMENT & DISCLOSING ANY INFORMATION TO FN.**

→ /S/ _____ [Rel: _____] → /S/ _____ [Rel: _____]
BENEFICIARY’S SIGNATURE & RELATIONSHIP **BENEFICIARY’S SIGNATURE & RELATIONSHIP**

On ____ / ____ /20____, before me, _____, a **Notary Public**, personally appeared _____
(Beneficiary(ies)) who acknowledge him/her self to be the person whose name and capacity is subscribed to the above Power of Attorney. IN WITNESS WHEREOF, I hereunto set my hand and official seal.

1 - Assumed name of Surety Capital Corporation

NOTARY PUBLIC SIGNATURE & STAMP

IRREVOCABLE ASSIGNMENT ("IA")

INSURED: _____

INSURANCE COMPANY, BUSINESS OR GOVERNMENT ENTITY ("ICBG"): _____

INSURANCE POLICY, PLAN, ANNUITY, CLAIM or BENEFIT # (S) ("Policy"): _____

FOR VALUE RECEIVED, the undersigned being all of the persons or entities equitably, legally, or through probate, entitled to receive and dispose of the benefits, payable now or in the future, under the Policy (individually and collectively "**Beneficiaries**"), **herby irrevocably assign, sell and/or transfer to** _____ ("**FH**") and its assigns, up to and including \$ _____ which is to be paid from **all the benefits**, proceeds, premium(s) and interest connected with the above INSURED and/or described Policy. In addition, the Beneficiaries assign & sell: accrued statutory or contractual interest from the date of death; unearned premiums; and all state and federal claims and causes of action against ICBG connected with the Policy or Insured, including but not limited to, all benefit, non-benefit ERISA¹ claims to FH and it assigns and agree all rights under the Policy shall be subrogated to FH and its assigns. The Beneficiaries hereby irrevocably consent to, authorize, and direct ICBG to make payments of the Policy benefits to FH and its assigns. The consideration for this IA is FH rendering funeral services or assisting with the disposition of remains of INSURED, which services have been specifically ordered and accepted by the undersigned, and if applicable, inclusive of advancing additional monies to the undersigned for personal benefit. **TIME IS OF THE ESSENCE. Beneficiaries hereby irrevocably authorize and direct the insurance company, third party administrator, record keeper or any business or government entity to deal directly with FH, its agent and assignee to give any information that they require regarding INSURED, Beneficiaries, and the Policy** either orally or in writing by email, fax, phone, and mail including confidential, personal and medical information to ensure: proper filing for and payment of Policy benefits, resolving any denial of Policy benefits, and determine the validity of any reason(s) for any delay of payment of Policy benefits, and **PROVIDING IMMEDIATE HELP FOR THE FAMILY TO SECURE TIMELY ARRANGEMENTS FOR INSURED'S FUNERAL or BURIAL.** The Beneficiaries 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 and any assignment thereof. In the event that any payment is made to FH and/or its assigns for the Policy that is in excess of the amount stated above, the Beneficiaries agree FH and/or its assigns will take possession of the excess amount for itself until such time as Beneficiaries agree in writing to its distribution. If after one year there is no agreement in writing to its distribution; the Beneficiaries agree excess funds belong solely to FH and/or its assigns. The Beneficiaries agree to hold in trust any proceeds received from the Policy that were assigned to FH and/or its assigns and return such proceeds immediately. The Beneficiaries agree to cooperate with the FH and its assigns to get the IA paid. If the Policy is not delivered with this IA, Beneficiaries represent after a diligent search the **Policy is LOST**. Beneficiaries agree a copy of this IA is intended to be treated as if it were the original and their undersigned signature is an electronic signature pursuant to 15 USCS § 7001. The Beneficiaries affirm & attest under penalty of perjury the **Insured is dead**. The Beneficiaries affirm and attest that they are of sound mind, 18 or older, understand the meaning of this IA, and are entering into this IA with the intent it be binding on them. Beneficiaries by their signature below agree to this IA and any reassignment of this IA. In the event any covenants and provisions are determined invalid, all other covenants and provisions will remain intact & enforceable. **IN WITNESS WHEREOF, WE HAVE HEREUNTO SET OUR HANDS AND SEALS THIS** _____ **DAY OF** _____, **20** _____.

→ /s/ _____ [Rel: _____]
BENEFICIARY'S SIGNATURE & RELATIONSHIP

→ /s/ _____ [Rel: _____]
BENEFICIARY'S SIGNATURE & RELATIONSHIP

IRREVOCABLE REASSIGNMENT ("IRA")

FOR VALUE RECEIVED, the undersigned FH does hereby irrevocably assign, transfer, and/or sell unto **First National ("FN"), P.O. Box 337030, Greeley, CO 80633**², its successors and assigns, all of FH's right, power, title and interest in, to and under the above IA and the Policy, including all benefits, subrogation rights and causes of action, and does hereby direct that all payments be made to FN, and does hereby direct that all payments be made to FN. FH hereby irrevocably appoints FN as its Agent & Attorney-in-Fact to act for FH with full power to make collection of, compromise, settle and receipt for the proceeds of the above Insured & Policy and authority to endorse checks; **order death certificates**; and complete & sign assignments, pre-need or insurance claim forms as fully as FH could do, with full power of substitution, hereby ratifying and approving anything that FN may do by virtue of the authority and rights given herein and this power of attorney is not affected by subsequent disability or incapacity of the undersigned including if undersigned subsequently ceases to do business. FH agrees this IRA is to be treated as if it were the original and the signature is an electronic signature pursuant to 15 USCS § 7001. The FH agrees to cooperate with FN to get IRA paid. **This IRA is NONRECOURSE factoring to FH** unless a breach of contract occurs where FN determines, in its sole discretion, there is fraud or negligence related to the IA or IRA or FH fails to cooperate with FN to get IRA paid. The FH agrees to hold in trust any proceeds received that were assigned to FN and return proceeds to FN immediately. FH hereby expressly consents and agrees 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 IRA and any assignment thereof. **FH affirms & attests under penalty of perjury the Insured is dead.** FH by their signature below agree to this IRA. All terms used in this IRA shall have the meaning herein and the above IA. **IN WITNESS WHEREOF, WE HAVE HEREUNTO SET OUR HANDS AND SEALS THIS** _____ **DAY OF** _____, **20** _____.

→/s/ _____
FUNERAL HOME / CEMETERIAN by AUTHORIZED SIGNATURE

FUNERAL HOME or CEMETERY NAME

On _____ / _____ / **20** _____, before me, _____, a **Notary Public**, personally appeared _____ (**Beneficiary(ies)**) and _____ (**Funeral Home Agent**) who acknowledge him/her self to be the person whose name and capacity is subscribed to the above IA & IRA. **IN WITNESS WHEREOF, I hereunto set my hand and official seal.**

1 - Employee Retirement Income Security Act ("ERISA").
2 - Assumed name of Surety Capital Corporation

NOTARY PUBLIC SIGNATURE & STAMP

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:

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Address</u>

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)

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 : _____