Union Security Life Insurance Company of New York

Administrative Office
P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085 • Fax 305.252.6910
Attn: DFS Claims Department

DEATH CLAIM FORM

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed)

☐ **1. Complete Section 1 (To be completed by person reporting the claim).**

☐ **2. Attach a copy of the certified death certificate.**

☐ **3. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including the top portion) covering the date the insured passed away.**

- To avoid late fees, continue to make payments until you receive notification that claim has been approved.

Fax completed form and all supporting documentation to 305.252.6910 or mail to:

DFS Claims Department
PO Box 977122
Miami FL 33197-7122

ONCE YOUR CLAIM IS RECEIVED

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

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All benefit payments are paid directly to creditor.

SECTION 1 - CLAIMANT'S INFORMATION				PLEASE PRINT
NAME OF FINANCIAL INSTITUTION OR STORE THAT ISSUED CREDIT CARD	CREDIT CARD - ACCOUNT NUMBER			
NAME OF PRIMARY CARDHOLDER	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -		
NAME OF DECEASED	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -		
DECEASED'S STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE	
TELEPHONE NUMBER OF PERSON COMPLETING FORM (DAY) ( )	TELEPHONE NUMBER OF PERSON COMPLETING FORM (EVENING) ( )	E-MAIL ADDRESS OF PERSON COMPLETING FORM (IF AVAILABLE)		

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization, or person having any records, data, or information concerning this claim to furnish such record, data, or information to the insurance company issuing my policy. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If, in fact, the furnished information is false, thereby inducing payment of claim, and the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give the insurance company issuing my policy the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall remain valid for the duration of the claim.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PRINT NAME	SIGNATURE	RELATIONSHIP TO DECEASED	DATE
	X		/ /

STREET ADDRESS / APT #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )