

FAST FUNDING® REQUEST

(Fax completed forms toll free to: 844.866.6083)

From: _____
(Funeral Home/Cemetery) (City & State) (Contact Person)

(Phone Number) (Fax Number) (Email Address)

Deceased: _____ Social Security # _____
(As it appears on Insurance Policy)
Date of Birth _____ Date of Death _____

Cause of Death: () Natural () Homicide () Suicide () Accident () Coroner Case/ Pending Death Certificate

Was the death local? () Yes () No Who picked the body up? _____
Funeral Home Phone#

Are there any other assignments related to this policy(s) that you are aware of? () YES () NO

Is this policy through an employer? () YES () NO If YES is deceased? () Employee () Rider on Employee Policy

If rider, what is the deceased relationship to employee? _____ Is Employee? () Active () Retired

If Employer coverage, provide name and phone number of Employer: _____

Insurance Information:

Policy # 1 _____ Insurance Co. _____

Beneficiary _____ Relationship _____

Policy # 2 _____ Insurance Co. _____

Beneficiary _____ Relationship _____

Policy # 3 _____ Insurance Co. _____

Beneficiary _____ Relationship _____

Policy # 4 _____ Insurance Co. _____

Beneficiary _____ Relationship _____

NOTE: If you have verified this claim, please furnish us the number you called for each insurance company and your contact person, if one: _____

Total Amount Assigned: \$ _____

Any additional information or requests: