

## **1010 ALL CAUSE DEATH BENEFIT ACTIVATION FORM**

COMPLETE FIELDS #1 THROUGH #5 ON THE SECOND PAGE OF THE FORM

PRINT THE FORM AFTER COMPLETING PAGE TWO

SIGN, DATE, AND FILL IN RELATIONSHIP AT THE BOTTOM OF PAGE TWO

PAGE ONE NEEDS TO BE COMPLETED BY THE LENDING INSTITUTION

ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE

RETURN PAGES ONE AND TWO ALONG WITH THE DEATH CERTIFICATE TO:

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

309-346-1161, x2329

## NOTICE OF DEATH PROTECTION BENEFITS

NAME OF CREDITOR		
ADDRESS		
CITY	STATE	ZIP
CUSTOMER/LOAN NUMBER	LOAN EFFECTIVE DATE	
AGENT CODE		

<b>INSTRUCTIONS</b>
1. Complete this form as soon as possible after death of Borrower.
2. Have nearest next of kin complete second page, sign authorization and return to you.
3. When this form is fully completed, attach: (a) Certified copy of Death Certificate (b) Copy of Loan Contract (c) If MOB, Copy of Ledger Sheet, Note, Authorization Card

**PEKIN LIFE INSURANCE COMPANY**  
**FINANCIAL PRODUCTS DEPARTMENT**  
**2505 COURT STREET, PEKIN, ILLINOIS 61558**

### PROOF OF DEATH – STATEMENT

Full Name of Deceased \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Date of Death \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Last 4 Digits of Soc. Sec. of Deceased \_\_\_\_\_

Loan Number	Date of Addendum	Original Term	Initial Amount of Loan	Minus Reduction Amount	= Benefit Amount
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

**TOTAL \$** \_\_\_\_\_

Loan payoff amount as of date of death \$ \_\_\_\_\_

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

\_\_\_\_\_  
 NAME OF FINANCIAL INSTITUTION ON ADDENDUM

\_\_\_\_\_  
 ADDRESS CITY & STATE

\_\_\_\_\_  
 SIGNATURE

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

**PEKIN LIFE INSURANCE COMPANY**  
**2505 Court Street**  
**Pekin, IL 61558**

**Indiana Claims:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Ohio Claims:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

TO BE COMPLETED BY THE NEAREST NEXT OF KIN:

1. Deceased's Name: \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

Please list any other names by which insured may have been known. \_\_\_\_\_

\_\_\_\_\_  
(Include maiden name, hyphenated name, nickname, derivative form of first and/or middle name, or alias.)

Date of Birth \_\_\_\_\_ Occupation at Death \_\_\_\_\_ Date Last Worked \_\_\_\_\_

2. When did deceased first complain or give other indications of this illness? \_\_\_\_\_

3. When did deceased first consult a physician for this illness? \_\_\_\_\_

4. Names and addresses of all physicians who treated the deceased within five years preceding death:

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

5. Names and addresses of all hospitals where deceased was confined:

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

Name \_\_\_\_\_ Street, City, State \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Disease or Condition \_\_\_\_\_

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

**DATE** \_\_\_\_\_ **Relationship to Deceased** \_\_\_\_\_

(Signature)