INSURANCE VERIFICATION FORM

Control Number ____________________

We need information about your insurance policies. Please complete Section I and have your life insurance representative complete Section II. We will deny, stop or change your benefits if you do not return this form within 10 days.

Section I: (to be completed by the client):

I, __________________________________ of ____
Name Address

authorize ____ to release information to the Department of Social
Life Insurance Company

Services.

Signature: ____________________________________ Date: __________________________________

Section II: To be completed by Life Insurance representative.
Please provide the following information for the above client and family members.

Insured	Policy Owner	Policy Number	Face Value	Current Cash Value
____________	____________	_____________	$_________	$_________
____________	____________	_____________	$_________	$_________
____________	____________	_____________	$_________	$_________
____________	____________	_____________	$_________	$_________

Representative's Signature: ____

Date: _________________________ Telephone:____