



**AUTHORIZATION FOR INSURANCE COMPANY TO
RELEASE LIFE INSURANCE POLICY INFORMATION
PURSUANT TO HIPAA**

Date: _____ Date of Death: _____

Decedent: _____

Date of Birth: _____ SS#: _____

Insurance Company: _____

Policy Number(s) _____

Beneficiary(s) _____

Relationship: _____

This is to inform you of the death of the above insured.

I/We are in the process of making funeral arrangements, and need to get the life insurance benefits verified so we can use the policy to pay for the funeral expenses.

I believe that I am the beneficiary of record, and am the responsible party for the funeral arrangements. **Therefore, I authorize you to release any information needed by ABM Funding, Inc. to verify the policy coverage and conditions, and agree to hold you harmless for doing so.**

This authorization is being requested pursuant to HIPAA.

Thank you for your **immediate attention** to this request.

Beneficiary's Signature

Beneficiary's Signature

Beneficiary's Signature

Beneficiary's Signature