FORD ACCEPTANCE CORPORATION

FAX: 847-797-5863

JOB INSURANCE VERIFICATION

DATE:____________ TIME:____________

FUNERAL HOME:____ PHONE NO:________________

CONTACT:____

NAME OF DECEASED:____

DATE OF DEATH:___________ CAUSE:_______________________ DATE OF BIRTH:____________

SOCIAL SECURITY NO:_________________________________ MARITAL STATUS_____

ACTIVE:___________ RETIRED:___________ DISABLED:___________

NAME OF EMPLOYER:____

LOCATION: CITY:________________________________ STATE:__________________________

PHONE NO: #_______________________ CONTACT:____

AMOUNT OF FUNERAL BILL: $__________________________

#1 BENEFICIARY:____ RELATIONSHIP:___________

DATE OF BIRTH:___________ SOCIAL SECURITY NO:______________________________

ADDRESS:____

#2 BENEFICIARY:____ RELATIONSHIP:___________

DATE OF BIRTH:___________ SOCIAL SECURITY NO:______________________________

ADDRESS:____

#3 BENEFICIARY:____ RELATIONSHIP:___________

DATE OF BIRTH:___________ SOCIAL SECURITY NO:______________________________

ADDRESS:____