

FORD ACCEPTANCE CORPORATION

FAX: 847-797-5863

INSURANCE VERIFICATION

DATE: _____

TIME: _____

FUNERAL HOME: _____ PHONE NO: _____

CONTACT: _____

NAME OF DECEASED: _____

DATE OF DEATH: _____ CAUSE: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____ MARITAL STATUS _____

INSURANCE COMPANY: _____ STATE LOCATION: _____

POLICY NO: _____ NO: _____ NO: _____

DO YOU HAVE POLICY(S): YES _____ NO: _____

ISSUE DATE: _____ DATE: _____ DATE: _____

POLICY AMOUNT: \$: _____ \$: _____ \$: _____

ASIGNMENT AMOUNT: \$ _____

POLICY #1 BENEFICIARY: _____ RELATIONSHIP: _____

#2 BENEFICIARY: _____ RELATIONSHIP: _____

#3 BENEFICIARY: _____ RELATIONSHIP: _____