



ADF

Accidental Death & Dismemberment

American National Insurance Company

MAIL PROCESSING CENTER, P.O. BOX 10546, SPRINGFIELD, MO 65808-0546
Email: Health.Disability&Life@AmericanNational.com

Toll-Free (800) 899-6520

Fax (866) 490-3164

Please send the completed form and certified death certificate to the above address.

1. Employer _____

2. Group Certificate Number _____

3. Member Information

(a) Name _____

(b) Address _____

(c) Date of Birth _____

(d) Cause of Accidental Death or Dismemberment _____

4. Claimant/Beneficiary Information

(a) Name _____

(b) Sex Male Female Date of Birth _____

(c) Street Address _____

(d) Mailing Address (if different than street address) _____

(e) Telephone Number _____

(f) Email Address _____

(h) Relationship to Deceased _____

5. Has the benefit been assigned to a Mortuary, Funeral Home or Cemetery? Yes No

 If yes, attach assignment.

Authorization: I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institution or person who has attended or examined the decedent to disclose to the American National Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

Signature _____ Date _____

FAILURE TO COMPLETE THIS AUTHORIZATION WILL REQUIRE THE FORM TO BE RETURNED TO YOU FOR COMPLETION.