LIFE INSURANCE VERIFICATION REQUEST

Clear

Date:_____

To:

RE: _____

Date of Birth:_____

SSN:_____

Section I: AGENCY REQUEST

The above named individual has applied for assistance from the State of Florida. In order to determine eligibility, the department must have verification of all income and resources.

Please complete Section II. Attached is a signed authorization for the release of this information. In order to establish eligibility as quickly as possible, we are requesting your response by _____ (10 days). Enclosed is an envelope for mailing the completed form to us.

Thank you very much for your prompt attention to this matter.

Sincerely,

_____
Name (print)

_____
Office Address

_____
Telephone Number

If applicable, enter "ext." and extension number

Section II: RESPONSE:

SUBJECT	Policy Number:	Policy Number:	Policy Number:
1. Name of Owner?			
2. Name of Insured?			
3. Face Value?			
4. Case Surrender Value?			
5. Is There An Outstanding Loan?			
6. Cash Surrender Value Less Indebtedness?			
7. Are Interest or Dividends Earned on the Policy?			
8. If So, What Is Payment Amount and Frequency?			

(Information on additional policies may be included on the back)

Signature of Insurance Company's Representative	Date Signed	Representative's Telephone Number
Title		