SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES VERIFICATION OF LIFE INSURANCE VALUES

From:	Worker:
	Telephone:
	Date of Request:
	Budget Group Number:
То:	Applicant/Beneficiary:
	Date of Birth:
	Social Security Number:

Dear Sir or Madam:

The above-mentioned individual has been or is presently insured by your company. In order to have an accurate record of this person's resources, certain information is required concerning his or her policy. Upon application, the individual or his authorized representative must sign a general disclosure statement that allows us to verify all possible resources. If not signed below, the general disclosure statement is on file in our office. Please provide the requested information on the reverse of this form, and sign and date at the bottom.

Thank you for your cooperation in this matter.

Sincerely,

South Carolina Department of Health and Human Services

I authorize any custodian of records at the insurance company named above to disclose to the South Carolina Department of Health and Human Services any records or information requested.

Authorized Representative:	Date:
Authorization Attached	

NOTE: PLEASE COMPLETE THE BACK OF THIS FORM

Policy Number:

Face Value	Type of Policy	Type of Policy		Date of Issue			
Insured	C		Owner				
Please give cash value:							
Year:\$	Year:	\$	Year:	\$			
Give date and amount of any o	utstanding loans:	Date:	Amount:				
If policy is paid up, give date and current value:		Date:	Cash or Loan Value:				
If policy has been cashed in, gi	ed: Date:	Amount Received:					
If policy has lapsed or been dropped, give date: Date:							
Does this policy pay dividends? Yes No If yes, what option has the individual selected for distribution?							
Option	Total Amount Received	Date and amour recent payr		How often are payments made?			

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Give date and amount of any o	utstanding loans:	Date:	Amount:				
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If policy has been cashed in, give date and amount received:			Amount Rec	Amount Received:			
If policy has lapsed or been dropped, give date: Date:							
Does this policy pay dividends	? □Yes □No	If yes, what optic	on has the individual se	elected for distribution?			
Option	Total Amount Rece	Ned	and amount of most ecent payment	How often are payments made?			

Comments:

Signature of Insurance Official Providing Information:

Date: _____

Telephone: _____