



TO GET STARTED: ● **COMPLETE THE IRREVOCABLE ASSIGNMENT and**
 ● **VERIFICATION OF CLAIM AND LIMITED DURABLE POWER OF ATTORNEY**
 ● **FAX BOTH FORMS WHEN SIGNED TO 817-850-9801 OR EMAIL to**
info@lincoln.com.

Call Lincoln Factoring at 817-850-9800 to make sure claim is received.

VERIFICATION OF CLAIM AND LIMITED DURABLE POWER OF ATTORNEY

INSURED NAME: _____ **SS#** _____
DATE OF BIRTH: _____ **DATE OF DEATH:** _____
PLACE OF DEATH: ADDRESS: _____ **CITY/STATE:** _____
CAUSE OF DEATH: Natural Homicide Suicide Accident Unknown (detail below)

INSURANCE BENEFIT: TYPE OF INSURANCE COVERAGE? GROUP POLICY? INDIVIDUAL POLICY?
 If **GROUP INSURANCE**, provide **Employer (Company Name)**, a **Contact Name**, & **Phone Number**:

INSURANCE COMPANY NAME _____
POLICY (IES) # for this Claim: _____

\$ _____ FUNERAL / CEMETERY BILL ASSIGNMENT WITH CASH ADVANCES

FUNERAL HOME NAME: _____

Beneficiary 1: _____
 Your Social Security #: _____ Date of Birth _____
 Relationship to Deceased: Parent Spouse/Life Partner Grandparent Aunt/Uncle Brother/Sister
 Son/Daughter Other (Explain): _____
 Address (City/State/Zip) & Phone #: _____

Beneficiary 2: _____
 Your Social Security #: _____ Date of Birth _____
 Relationship to Deceased: Parent Spouse/Life Partner Grandparent Aunt/Uncle Brother/Sister
 Son/Daughter Other (Explain): _____
 Address (City/State/Zip) & Phone #: _____

DIRECTIVE and LIMITED DURABLE POWER OF ATTORNEY

TO WHOM IT MAY CONCERN: Upon presentation of this form, or a photo static copy thereof which is as valid as the original, you are authorized and directed to disclose insurance information and any documents required to settle the life policy described above to Lincoln Factoring¹ ("LF"), its assigns or its representatives. The undersigned Beneficiary(ies) hereby irrevocably authorize(s) and direct(s) the issuer or sponsor of the Policy, third party administrator, record keeper or any business or government entity to deal directly with LF to give any information that LF requires regarding INSURED, Beneficiaries, and the insurance policy by email, fax, phone, and mail including confidential, personal and medical information to ensure: proper filing for and payment of insurance policy benefits, resolving any denial of insurance policy benefits, and determine the validity of any reason(s) for any delay of payment of insurance policy benefits, and **providing immediate HELP FOR THE FAMILY TO SECURE TIMELY ARRANGEMENTS FOR INSURED'S FUNERAL or BURIAL**. In addition the undersigned Beneficiary(ies) individually hereby **expressly: (1)** authorize disclosure of Protected Health Information of INSURED pursuant to HIPAA 45 C. F. R. 164.512 to LF; **(2) irrevocably appoint LF as agent and Attorney-in-Fact** with full power of substitution, to act for such Beneficiary(ies) with full power and authority to (i) enforce collection of, compromise, settle and give receipt for the benefits & proceeds of the insured and/or insurance benefit described above, (ii) endorse checks and benefit forms in such Beneficiary's individual, estate representative, and trustee capacity, (iii) receive, complete and file claim forms or packets, (iv) receive information concerning the insured, beneficiary & insurance policy, (v) obtain INSURED'S insurance plan documents (vi) receive medical or confidential information (vii) add, redo or amend assignments of the above described insured and/or insurance benefit to correct errors, clarify ambiguities, and give further legal effect to the purpose and intent hereof, (viii) order death certificates of INSURED, (ix) insert Beneficiary's signature on claim, insurance complaint, small estate, assignment, tax, funeral bill or benefit forms as fully as Beneficiary could personally do, **(3)** ratify and confirm all that their attorney in fact may do or cause to be done by virtue of the authority and direction given herein, and **(4)** this power of attorney is not affected by subsequent disability or incapacity of any undersigned principal.

→ /S/ _____ [Rel: _____] → /S/ _____ [Rel: _____]
BENEFICIARY'S SIGNATURE & RELATIONSHIP **BENEFICIARY'S SIGNATURE & RELATIONSHIP**

On ___/___/20___, before me
 , _____, a **Notary Public**, personally appeared _____ (**Beneficiary(ies)** who acknowledge him/her self to be the person whose name and capacity is subscribed to the above Power of Attorney. IN WITNESS WHEREOF, I hereunto set my hand and official seal.

NOTARY PUBLIC SIGNATURE & STAMP

1 - Assumed name of Surety Capital Corporation



IRREVOCABLE ASSIGNMENT ("IA")

INSURED: _____

INSURANCE COMPANY, BUSINESS OR GOVERNMENT ENTITY ("ICBG"): _____

INSURANCE POLICY, PLAN, ANNUITY, CLAIM or BENEFIT # (S) ("Policy"): _____

FOR VALUE RECEIVED, the undersigned being all of the persons or entities equitably, legally, or through probate, entitled to receive and dispose of the benefits, payable now or in the future, under the Policy (individually and collectively "**Beneficiaries**"), **hereby irrevocably assign, sell and/or transfer to** _____ ("**FH**") and its assigns, up to and including \$_____ which is to be paid from **all the benefits**, proceeds, premium(s) and interest connected with the above INSURED and/or described Policy including any return of premiums. In addition, the Beneficiary(ies) assign, sell, and/or transfer all of their claims and causes of action connected with the Policy, including but not limited to, all benefit and non-benefit ERISA¹ claims and all accrued **statutory or contractual interest** from the date of death and unearned premiums to FH and its assigns. The Beneficiaries hereby irrevocably consent to, authorize, and direct ICBG to make payments of the Policy benefits to FH and/or its assigns. The consideration for this IA is FH rendering funeral services or assisting with the disposition of remains of INSURED, which services have been specifically ordered and accepted by the undersigned, and if applicable, inclusive of advancing additional monies to the undersigned's personal benefit. **TIME IS OF THE ESSENCE. Beneficiary(ies) hereby irrevocably authorize(s) and direct(s) the issuer or sponsor of the Policy, third party administrator, record keeper or any business or government entity to deal directly with FH, its agent and assignee to give any information that they require regarding INSURED, Beneficiaries, and the Policy by email, fax, phone, and mail including confidential, personal and medical information to ensure: proper filing for and payment of Policy benefits, resolving any denial of Policy benefits, and determine the validity of any reason(s) for any delay of payment of Policy benefits, and providing immediate HELP FOR THE FAMILY TO SECURE TIMELY ARRANGEMENTS FOR INSURED'S FUNERAL or BURIAL.** The Beneficiaries hereby expressly consent and agree to personally submit to the jurisdiction of all levels of any and all State and Federal Courts located in Tarrant County, the State of Texas, arising out of any and all litigation which occurs as a result of any dispute regarding this IA and any assignment thereof. Beneficiary(ies) agree if any inaccurate information is given by them to FH and/or its assigns that results in FH or its assigns receiving less than FH's charges and/or advances, the Beneficiary (ies) must pay back such losses immediately. In the event that any payment is made to FH and/or its assigns for the Policy that is in excess of the amount stated above, the Beneficiary(ies) agree FH and/or its assigns will take possession of the excess amount for itself until such time as Beneficiary(ies) agree in writing to its distribution. If after one year there is no agreement in writing to its distribution; the Beneficiary (ies) agree excess funds belong solely to FH and/or its assigns. The Beneficiary(ies) agree to hold in trust any proceeds received from the Policy that were assigned to FH and/or its assigns and return such proceeds immediately. **If the Policy is not delivered with this IA, Beneficiary(ies) represent after a diligent search the Policy is LOST.** Beneficiary(ies) agree a copy of this IA is intended to be treated as if it were the original and is intended to be used as an electronic signature pursuant to 15 USCS § 7001. **The Beneficiary(ies) affirm & attest the Insured is dead.** The Beneficiary(ies) affirm and attest that they are of sound mind, 18 or older, understand the meaning of this IA, and are entering into this IA with the intent it be binding on them. Beneficiary(ies) by their signature below agree to any reassignment of this IA. In the event any covenants and provisions are determined invalid, all other covenants and provisions will remain intact & enforceable. **IN WITNESS WHEREOF, WE HAVE HEREUNTO SET OUR HANDS AND SEALS THIS** _____ **DAY OF** _____, **20** _____.

→ /s/ _____ [Rel: _____]
BENEFICIARY'S SIGNATURE & RELATIONSHIP

→ /s/ _____ [Rel: _____]
BENEFICIARY'S SIGNATURE & RELATIONSHIP

IRREVOCABLE REASSIGNMENT ("IRA")

FOR VALUE RECEIVED, the undersigned FH does hereby irrevocably assign, transfer, and/or sell unto **LINCOLN FACTORING ("LF") 6145 WEDGWOOD DR, FORT WORTH, TX 76133** ², its successors and assigns, all of FH's right, power, title and interest in, to and under the above IA and the Policy, including without limitation benefits and causes of action, and does hereby direct that all payments be made to LF, hereby ratifying and approving anything that LF may do by virtue of the authority and rights given herein. FH hereby irrevocably appoints LF and its representatives as its Agent & Attorney-in-Fact to act for it with full power to make collection of, compromise, settle and receipt for the proceeds of the above Insured & Policy and authority to endorse checks; order death certificates; and complete pre-need or insurance claim forms as fully as FH could do, with full power of substitution and this power of attorney is not affected by subsequent disability or incapacity of the undersigned including if undersigned subsequently ceases to do business. FH agrees this IRA is intended to be treated as if it were the original and to be used as an electronic signature pursuant to 15 USCS § 7001. In addition, without limitation, the undersigned FH assigns to LF the right to collect monies from any person(s) who is/are liable for INSURED's funeral and/or cemetery expenses. **This IRA is Non-recourse factoring to FH provided there is no fraud or misrepresentation of any information given by Beneficiaries to FH or FH to LF.** Otherwise, if information is misrepresented, a breach of contract occurs: then on demand, FH promises to pay to the order of LF the amount assigned with interest at the highest permissible rate allowed under Texas law until paid. The FH agrees to hold in trust any proceeds received that were assigned to LF and return proceeds to LF immediately. This IRA is submitted by the FH at LF's principle place of business and shall be deemed to have been made there. FH hereby expressly consents and agrees to personally submit to the jurisdiction of all levels of any and all State and Federal Courts located in Tarrant County, the State of Texas, arising out of any and all litigation which occurs as a result of any dispute regarding this IRA and any assignment thereof. **FH affirms & attests the Insured is dead.** FH by their signature below agree to this IRA. All terms used in this IRA shall have the meaning herein and the above IA. **IN WITNESS WHEREOF, WE HAVE HEREUNTO SET OUR HANDS AND SEALS THIS** _____ **DAY OF** _____, **20** _____.

→/s/ _____
FUNERAL HOME / CEMETERIAN by AUTHORIZED SIGNATURE

FUNERAL HOME or CEMETERY NAME

On _____ / _____ /20____, before me, _____, a **Notary Public**, personally appeared _____ (**Beneficiary(ies)**) and _____ (**Funeral Home Agent**) who acknowledge him/her self to be the person whose name and capacity is subscribed to the above Power of Attorney. **IN WITNESS WHEREOF, I hereunto set my hand and official seal.**

1 - Employee Retirement Income Security Act ("ERISA").
2 - Assumed name of Surety Capital Corporation

NOTARY PUBLIC SIGNATURE & STAMP