

# REQUEST FOR INSURANCE DATA



CAO ADDRESS

CASE IDENTIFICATION				
Co	Record Number	Category	Ctr. Dig.	Dist.
RECORD NAME				
WORKER			DATE	

PLEASE RETURN THIS FORM TO THE ADDRESS SHOWN ABOVE

CAO DATA		
NAME OF INSURED	BIRTHDATE	SOCIAL SECURITY NUMBER
ADDRESS OF INSURED		

The insured is unable to furnish the information requested below, as indicated by check marks. We have in our files the signed permission for release of this information, which will be considered strictly confidential. Your cooperation in completing the items checked will be appreciated.

\_\_\_\_\_  
For County Assistance Office

<b>NOTE:</b> Check only necessary items under columns headed by POLICY NUMBER.	<input checked="" type="checkbox"/>	POLICY NUMBER	<input checked="" type="checkbox"/>	POLICY NUMBER	<input checked="" type="checkbox"/>	POLICY NUMBER
KIND OF POLICY						
FACE AMOUNT OF POLICY <small>(Exclusive of Dividend Additions)</small>						
DATE ISSUED						
AGE AT ISSUE						
AMOUNT OF PREMIUM						
STATUS OF POLICY						
IF LAPSED, HAS POLICY ANY REMAINING VALUE						
POLICY LIENS OR LOANS						
PRESENT NET CASH SURRENDER VALUE <small>(If net CSV is available to more than one insured please list breakdown)</small>						
IF CASH SURRENDERED SINCE DATE <small>1 Year Prior to Date Assistance Began</small>	▶	Amount Paid				
		Date Paid				
PRESENT NET PAID-UP VALUE						
PRESENT CLAIM VALUE						
EXPIRY DATE OF EXTENDED INSURANCE						
NAME OF BENEFICIARY AND RELATIONSHIP						
ADDITIONAL INSURANCE ON THIS LIFE						
ITEMIZE SICK AND ACCIDENT BENEFITS	▶	Amount Paid				
<small>Between</small> Date                      Date		Date Paid				
_____ and _____						
NAME OF OWNER IF OTHER THAN INSURED <small>(Can owner obtain CSV without insured's consent)</small>		(    ) Yes    (    ) No		(    ) Yes    (    ) No		(    ) Yes    (    ) No
<small>(Use "OTHER" space if necessary)</small>						
OTHER ▶						
<small>(Specify)</small>						

**Insurance Agency Address**

\_\_\_\_\_  
SIGNED FOR INSURANCE COMPANY




\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

FORM RETENTION - RETAIN UNTIL NEXT REAPPLICATION





NOTE: Check only necessary items under columns headed by POLICY NUMBER.	✓	POLICY NUMBER	✓	POLICY NUMBER	✓	POLICY NUMBER
KIND OF POLICY						
FACE AMOUNT OF POLICY <i>(Exclusive of Dividend Additions)</i>						
DATE ISSUED						
AGE AT ISSUE						
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ITEMIZE SICK AND ACCIDENT BENEFITS Between Date and Date  Amount Paid Date Paid						
NAME OF OWNER IF OTHER THAN INSURED <i>(Can owner obtain CSV without insured's consent)</i>		( ) Yes ( ) No		( ) Yes ( ) No		( ) Yes ( ) No
<i>(Use "OTHER" space if necessary)</i>						
OTHER  <i>(Specify)</i>						
REMARKS:						