

**TO GET STARTED:** ● **COMPLETE THE IRREVOCABLE ASSIGNMENT and**  
 ● **VERIFICATION OF CLAIM AND LIMITED DURABLE POWER OF ATTORNEY**  
 ● **FAX BOTH FORMS WHEN SIGNED TO 817-984-8809 OR EMAIL [veronica@sryp.net](mailto:veronica@sryp.net)**  
*Call Surety Capital Corporation at 817-294-8888 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:** \_\_\_\_\_

<p><b>Beneficiary 1:</b> _____          Your Social Security #: _____ Date of Birth _____          Relationship to Deceased: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse/Life Partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Brother/Sister  <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Other (Explain): _____          Address (City/State/Zip) &amp; Phone #: _____</p>
<p><b>Beneficiary 2:</b> _____          Your Social Security #: _____ Date of Birth _____          Relationship to Deceased: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse/Life Partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Brother/Sister  <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Other (Explain): _____          Address (City/State/Zip) &amp; Phone #: _____</p>

**DIRECTIVE and LIMITED DURABLE POWER OF ATTORNEY COUPLED WITH AN INTEREST  
 THIS IS NOT A FIDUCIARY RELATIONSHIP**

*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 Surety Capital Corporation (“SRYP”), its assigns or its representatives. The undersigned principals and/or beneficiary(ies) individually hereby **expressly: (1) authorize disclosure of Protected Health Information of INSURED & BENEFICARY pursuant to HIPAA 45 C. F. R. 164.512 to SRYP; (2) irrevocably appoint SRYP as my agent and Attorney-in-Fact with full power of substitution, to act for me with full power and authority to (i) enforce collection of, compromise, assign, settle and give receipt for any benefits & proceeds connected with or related to Insured & Beneficiary(ies) to the extent necessary to fully cover Insured’s funeral cost or assignment amount, (ii) endorse or sign: claim forms, checks, assignments and estate forms in my individual, estate representative, and trustee capacity,(iii) receive, complete and sign my name to any claim, assignment, probate or small estate forms connected with or related to Insured or beneficiary, (iv) receive any insurance documents & medical and confidential information concerning the Insured & Beneficiary, (v) redo assignments or insert, add or amend policy information on assignments & forms of Insured & Beneficiary to correct errors, clarify ambiguities, and give further legal effect to the purpose and intent hereof, (vi) order death certificates or birth certificates of Insured, (vii) insert or copy my signature on claim, assignment, funeral bill, small estate, tax, complaint or benefit forms as fully as principal or beneficiary could personally do, (3) ratify and confirm all that my 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. The undersigned 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 Directive or Limited Durable Power of Attorney and any assignment thereof. The undersigned agrees a copy of this agency agreement is to be treated as the original and my/our signature is to be used as an electronic signature pursuant to 15 USCS § 7001. The undersigned understands this agency agreement is coupled with SRYP’s interest in the above described insurance proceeds. **THE UNDERSIGNED AGREE TO INDEMNIFY & HOLD HARMLESS ANY ENTITY OR PERSON FROM LIABILITY BY HONORING THIS POWER OF ATTORNEY, DISCLOSING INFORMATION & PAYING ASSIGNED AMOUNT TO SRYP.****

→ /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.

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**"), **herby 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. In addition, the Beneficiaries assign & sell: accrued **statutory or contractual interest** from the date of death; unearned premiums; and all state and federal claims and causes of action against ICBG connected with the Policy or Insured, including but not limited to, all benefit, non-benefit ERISA<sup>1</sup> claims to FH and it assigns and agree all rights under the Policy shall be subrogated 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 for personal benefit. **TIME IS OF THE ESSENCE. Beneficiary(ies) hereby irrevocably authorize(s) and direct(s) the issuer or sponsor of the Policy, insurer, 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. The Beneficiaries agree to cooperate with the FH and its assigns to get the IA paid. 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) & FH 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 under penalty of perjury 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 this IA and 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, convey and/or sell unto **Surety Capital Corporation ("SC") LOCK BOX 123550, FORT WORTH, TX 76121-3550**, 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 all benefits, subrogation rights and causes of action, and does hereby direct that all payments be made to SC. FH hereby irrevocably appoints SC and its representatives as its **Agent & Attorney-in-Fact to act for FH** with full power to make collection of, compromise, settle and receipt for the proceeds of the above Insured & Policy and authority to endorse & sign: checks, assignments, pre-need or insurance claim forms **and order death certificates** of Insured 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. The FH agrees to cooperate with SC to get IRA paid. **This IRA is NONRECOURSE factoring to FH** unless a breach of contract occurs where SC determines, in its sole discretion, there is fraud or negligence related to the IA or IRA or FH fails to cooperate with SC to get IRA paid. The FH agrees to hold in trust any proceeds received that were assigned to SC and return proceeds to SC immediately. 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 under penalty of perjury the Insured is dead**. FH by its 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 IA & IRA. **IN WITNESS WHEREOF, I hereunto set my hand and official seal.**

1 - Employee Retirement Income Security Act ("ERISA").

**NOTARY PUBLIC SIGNATURE & STAMP**