



**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 Herrera Financial 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:** \_\_\_\_\_

**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 Herrera Financial ("HF")<sup>1</sup>, 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 HF to give any information that HF 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 HF; **(2) irrevocably appoint HF 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, packets, and insurance complaints (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, assignment, tax, small estate complaint 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.

1 - Assumed name of Surety Capital Corporation

\_\_\_\_\_  
**NOTARY PUBLIC SIGNATURE & STAMP**



**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 ERISA<sup>1</sup> 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 **Herrera Financial ("HF") 6145 Wedgwood Drive, Fort Worth, Texas 76133** <sup>2</sup>, 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 HF, hereby ratifying and approving anything that HF may do by virtue of the authority and rights given herein. FH hereby irrevocably appoints HF 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 HF 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 HF.** Otherwise, if information is misrepresented, a breach of contract occurs: then on demand, FH promises to pay to the order of HF 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 HF and return proceeds to HF immediately. This IRA is submitted by the FH at HF'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 IA & IRA. **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**