Herrera FINANCIAL COMPANY

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***
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") [1], 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.

_____
NOTARY PUBLIC SIGNATURE & STAMP

1 - Assumed name of Surety Capital Corporation

Herrera FINANCIAL COMPANY

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[1] 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 that 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** [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 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

Herrera
FINANCIAL COMPANY

ONE AND THE SAME PERSON AFFIDAVIT

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned authority, a Notary Public in and for the State of _____, on this day personally appeared, known to me, and who, after being by me duly sworn on oath stated:

My name is _____ whose date of birth is _____.

I am and was one and the same person as _____.
I am making this statement under oath in order to induce payment of _____
Life insurance company, Policy Number(s) _____.

Executed on this _____ day of _____ , _____.

AFFIANT:

_____

SUBSCRIBED AND SWORN TO BEFORE ME, on this ____day of _____ , _____.

_____ NOTARY PUBLIC, STATE OF _____

MY COMMISSION EXPIRES : _____

Herrera
FINANCIAL COMPANY

SMALL ESTATE AFFIDAVIT

STATE OF: _____) SS.
COUNTY OF:_____)

_____, residing at _____
(Affiant's Address)

being duly sworn, deposes and says:

_____, insured under policy number(s)_____
(Insured/Deceased)

issued by_____ died on the date of _____
(Insurance Company)

leaving no will, and that no petition for the appointment of an executor or administrator of the decedent's estate has been granted, is pending or contemplated; that all of the bills, debts, expenses, taxes and charges of whatsoever kind or nature of either said decedent or said Decedent's Estate have been paid **except for funeral expenses** in the amount of _____; and that the gross value to the Decedent's real and personal property, excluding exempt property, does not exceed $_____.

The following relatives of the decedent were surviving at the time of the decedent's death:

Relationship	Name	Age	Address

The names of heirs-at-law of the decedent are listed above and there are no others who could claim an interest in the estate.

The undersigned recognizes that the Insurance Company will rely on this Affidavit, agrees to indemnify Insurance Company from any claim of suit (including Attorney's fees) filed arising out of the subject policy, and request said Insurance Company to waive the requirement of administration and honor the instructions attached to the affidavit.

_____
(Signature of Affiant)

_____
(Relationship of the Decedent)

Subscribed and sworn to before me this_____day of_____, 20____.

_____ _____
(SIGNATURE OF NOTARY PUBLIC) (NOTARY STAMP OR SEAL)

UNIVERSAL AFFIDAVIT FOR LOST POLICY

I (We), the undersigned, hereby certify and upon oath represent that Policy number _____ for $ _____, issued on the life of _____, insured, on the ____ day of _____, _____, has been lost or destroyed and that said policy is not assigned, hypothecated or pledged except to **HERRERA FINANCIAL COMPANY, 6145 WEDGWOOD DR, FORT WORTH, TEXAS 76133** in any way whatsoever; that I (We) the undersigned, am (are) the beneficiary under paid policy, and that this policy became a claim due to the death of the aforesaid insured, on the ___ day of _____, 20____. It is distinctly understood and agreed that should the original policy be found, it is to be returned to the _____ its successors or assigns.

I (We) further agree that if any other person should surrender the policy to the INSURANCE COMPANY and make demand for the payment therefore from the company claiming to own the policy by virtue of a gift of said policy from the insured top such other persons during the lifetime of the insured and should a Court of Law or Equity Judicially determine that such other person or persons rather that the undersigned is entitled to be paid the proceeds of this policy then in that event, I (We) agree to reimburse said company for the amount so paid to the undersigned.

_____

Signature

_____

Signature

HERRERA FINANCIAL COMPANY
6145 WEDGWOOD DR•FORT WORTH, TX 76133•817-294-8888•FAX 817-984-8809
www.herrerafinancial.net