1019 HOSPITALIZATION BENEFIT ACTIVATION

FILL OUT PART ONE, BE SURE TO COMPLETE FIELDS #1 THROUGH #17 c

PRINT THE FORM AFTER COMPLETING THE ABOVE INDICATED FIELDS

SIGN AND DATE PAGE ONE

HAVE PAGE TWO COMPLETED BY YOUR PHYSICIAN

RETURN BOTH PAGES TO:

PEKIN LIFE INSURANCE COMPANY
ATTN: FINANCIAL PRODUCTS BENEFITS DEPT.
2505 COURT STREET
PEKIN IL 61558

309-346-1161, x2521

Hospitalization
Benefits Activation Form

Reset

FINANCIAL INSTITUTION – COMPLETE THIS SECTION BEFORE GIVING FORM TO PROTECTED BORROWER

Name of Insured in full _____

Customer ID number _____ Term of Loan _____ Loan Date _____

Creditor _____ Agent # _____

Completed by _____ Title _____ Date _____ Phone _____

Please complete all fields. Missing information may cause processing delays.

Part 1 – To be completed by Protected Borrower

1. Customer ID Number	2. Last 4 Digits of Social Security Number	3. Date of Birth		
4. Last Name	5. First Name	6. Middle Initial		
7. Address	8. City	8a. State	8b. Zip	
9. Phone Number	10. Has your loan been refinanced? ❑ Yes ❑ No If yes, please provide prior loan number.			
11. Diagnosis/Condition you were hospitalized for?				
12. Dates Hospitalized: _____ to _____	13. Name & Phone Number of Hospital _____			
14. Attending Physician's Name				
15. Attending Physician's Phone Number (Required)	16. Attending Physician's Fax Number			
17. Attending Physician's Street Address (Required)	17a. City	17b. State	17c. Zip	

I hereby certify that the answers given above are full and true.

_____ _____

Signature **Date**

Please Complete Page 2

Return completed forms to:
Pekin Life Insurance Company, Financial Products Benefit Activation, 2505 Court Street, Pekin, IL 61558.

Hospitalization Benefits Activation Form – Page 2

Please complete all fields. Missing information may cause processing delays.

Part 2 – To be completed by Physician

18. Diagnosis and Concurrent Condition		19. Was hospitalization due to pregnancy? ❑ Yes ❑ No	
20. Was patient hospitalized ❑ Yes ❑ No	21. Name of Hospital		
22. Hospital admission date (mo-day-yr)		23. Hospital release date (mo-day-yr)	
24. Attending Physician's Printed Name		25. Street Address	
26. City		27. State	28. Zip Code
29. Phone Number (Required)		30. Fax Number (Required)	
31. Attending Physician's Signature			32. Date

Return completed forms to:
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