



American Capital Funding

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ADVANCE REQUEST

Fax completed form to: (800) 380-5504

Request Date: _____ Contact Person: _____ Requested Amt: \$ _____

Funeral Home / Cemetery Name: _____

Phone: _____ Fax: _____ Email: _____

DECEASED INFORMATION

Name of the Deceased: _____

Social Security#: _____ Date of Birth: _____ Date of Death: _____

Deceased Address: _____

Cause of Death (Check One): _____ Natural _____ Suicide _____ Homicide _____ Accident _____ Pending

Marital Status: _____ Married _____ Divorced _____ Widowed _____ Not Married _____ # of Surviving Children

INSURANCE INFORMATION

Name of FH/Cemetery taking an assignment & their amount: _____

Name of Insurance Co:			
Policy Number	Beneficiary Name	Amount (if known)	Original Policy Avail
			___ Yes ___ No
			___ Yes ___ No
			___ Yes ___ No

Name of Insurance Co:			
Policy Number	Beneficiary Name	Amount (if known)	Original Policy Avail
			___ Yes ___ No
			___ Yes ___ No
			___ Yes ___ No

Name of Insurance Co:			
Policy Number	Beneficiary Name	Amount (if known)	Original Policy Avail
			___ Yes ___ No
			___ Yes ___ No
			___ Yes ___ No

If employer provided coverage is the deceased the (check one) _____ employee or _____ a spouse/child rider?

Name of Employer: _____

Contact Person: _____ Contact#: _____

Additional comments: _____

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Newport News, VA 23607

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