REQUEST FOR VERIFICATION OF LIFE INSURANCE POLICY INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE DIVISION
SFN 363 (6-2015)

Clear Fields

TO BE COMPLETED BY THE CLIENT

Name	Social Security Number *	Date of Birth	
Address	City	State	ZIP Code
Name of Insurance Company		Policy Number	
Address	City	State	ZIP Code
Provide Information to this County Social Services Office			
* In compliance with the Federal Privacy Act of 1974, disclose of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.			
Client Signature		Date	

TO BE COMPLETED BY THE INSURANCE COMPANY

Date Information Provided			
Type of Policy ☐ Term ☐ Whole Life ☐ Paid Up ☐ Other-Explain:			
Name of Policy Owner		Name of Insured	
Face Value	Earnings	Remaining Cost Basis *	Loans
* Remaining Cost Basis is **the total premiums that have been paid by the above individual less amounts paid** for any riders and less any withdrawals of premiums paid. *			
Have any premiums been paid by someone other than the policy owner or the insured? ☐ No ☐ Yes - Who Paid the Premium?			
Amount of Premiums Paid by Someone other than the Policy Owner or the Insured?		Cash Surrender Value **	
** (Amount should include dividends, outstanding loans, etc. to arrive at net cash surrender value available)			
Date Issued	Beneficiary(ies)		
Has this policy been annuitized? ☐ No ☐ Yes - Date Payment Option Chosen:			
Frequency of Payments	Amount of Payments	Guaranty Period of if for 'Life'	
Verified By		Date	
Title	Telephone Number	Fax Number	

A return envelope is provided for your convenience in responding to this request. Be sure to complete and sign before returning.

Return To		County Social Services		
Address		City	State ND	ZIP Code
Telephone Number	Fax Number	Email Address		