



UNITY FUNDING COMPANY, LLC

PO Box 625700 Cincinnati, Ohio 45262
 Phone: 855.414.8814 | Fax: 513.247.0627 | claims@unityfundingco.com

APPLICATION FOR ADVANCE

Firm Name					
Location					
Phone		Fax:		Email:	

Name of Deceased		Deceased SSN:	
Deceased Date of Birth		Deceased Date of Death:	
Deceased Address			
Policy Number(s)			

DECEASED CAUSE OF DEATH: Natural Homicide Suicide Accident Coroner/Case Pending

DECEASED PLACE OF DEATH: City: _____ State: _____

EMPLOYER POLICY? YES or NO | If YES, EMPLOYEE or RIDER | ACTIVE or RETIRED

If employer coverage provide name and phone number of employer: _____

Insurance Co.	Insurance Co.	Insurance Co.
Policy Number	Policy Number	Policy Number
Beneficiary Name	Beneficiary Name	Beneficiary Name
Beneficiary SSN	Beneficiary SSN	Beneficiary SSN
Beneficiary DOB	Beneficiary DOB	Beneficiary DOB
Beneficiary Relationship	Beneficiary Relationship	Beneficiary Relationship
Beneficiary Phone Number	Beneficiary Phone Number	Beneficiary Phone Number
Beneficiary Address	Beneficiary Address	Beneficiary Address
Beneficiary City, State & Zip	Beneficiary City, State & Zip	Beneficiary City, State & Zip

Funeral Amount: \$ _____ Additional Funds: \$ _____ <small>Unity Funding Company's Full Funding Feature</small>	Is the original policy or copy of the policy available? <input type="checkbox"/> Yes <input type="checkbox"/> No May we contact the beneficiary for verification purposes only? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you aware of any assignments/loans related to this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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TOTAL ASSIGNED AMOUNT \$ _____

Funeral Home Rep Requesting Funding: (Printed Name) _____ (Signature) _____ (Date) _____

UNITY FUNDING COMPANY, LLC | PO Box 625700 Cincinnati, OH 45262-5700

Irrevocable Assignment and Power of Attorney

FOR VALUE RECEIVED, I (WE), THE UNDERSIGNED BENEFICIARY(IES) UNDER THE INSURANCE POLICY(IES), OR DEATH BENEFIT CERTIFICATE NUMBER, OR BEING THE PERSON ENTITLED TO THE BENEFITS THEREUNDER ON:

POLICY NUMBER(S): _____

AND ANY OTHER POLICIES ISSUED BY _____ ON THE LIFE OF _____

INSURANCE COMPANY NAME

DO HEREBY IRREVOCABLY ASSIGN, SET OVER AND TRANSFER UNTO

NAME OF INSURED _____ ITS SUCCESSORS AND ASSIGNS THE SUM OF

NAME OF FUNERAL HOME/CEMETERY _____ | \$ _____

WRITE OUT TOTAL ASSIGNED AMOUNT

DOLLAR AMOUNT

PLUS STATUTORY INTEREST FROM THE INSURED'S DATE OF DEATH, WHICH IS TO BE PAID FROM THE BENEFITS OF THE POLICY(IES) OR CERTIFICATE(S) REFERENCED ABOVE. THE CONSIDERATION FOR THE ASSIGNMENT OF THIS AMOUNT BEING (1) FUNERAL AND/OR CEMETERY GOODS AND SERVICES PROVIDED FOR THE DECEASED BY THE FUNERAL HOME AND/OR CEMETERY, WHICH SERVICES HAVE BEEN ACCEPTED BY US AND/OR (2) ADVANCE PAYMENT OF PROCEEDS OF THE POLICIES REFERENCED ABOVE. I (WE) HEREBY AUTHORIZE AND DIRECT THE INSURANCE COMPANY NAMED ABOVE TO PAY \$ _____ TO **UNITY FUNDING COMPANY, LLC**, AT 4675 CORNELL RD., STE. 160, CINCINNATI OH 45241. IN THE EVENT THAT ANY PAYMENT(S) OF THE SAID PROCEEDS ARE ERRONEOUSLY PAID TO ME (US) BY THE INSURANCE COMPANY LISTED ABOVE, SUBSEQUENT TO THE EXECUTION OF THIS ASSIGNMENT TO THE FUNERAL HOME AND/OR CEMETERY NAMED ABOVE OR THE REASSIGNMENT BY THE FUNERAL HOME AND/OR CEMETERY TO **UNITY FUNDING COMPANY, LLC**, THEN I (WE) AGREE TO IMMEDIATELY REMIT SAID FUNDS TO **UNITY FUNDING COMPANY, LLC**. I (WE) APPOINT **UNITY FUNDING COMPANY, LLC** AS OUR ATTORNEY IN FACT TO ACT FOR ME (US) WITH FULL POWER TO MAKE COLLECTION OF, COMPROMISE SETTLE AND TO ENDORSE OR RECEIPT IN MY (OUR) NAMES, OR OTHERWISE, ANY CHECK, DRAFT, RECEIPT, OR RELEASE OF THE PROCEEDS OF SAID POLICY(IES) OF INSURANCE OR CERTIFICATE AND TO PROCESS ALL NECESSARY FORMS, EXECUTE PROOFS OF LOSS OR PROOFS OF CLAIM AND TO EXECUTE ALL NECESSARY PAPERWORK TO OBTAIN SAID INSURANCE PROCEEDS, AS FULLY TO ALL INTENTS AND PURPOSES AS WE OURSELVES COULD DO, HEREBY RATIFYING AND CONFIRMING ALL THAT OUR SAID ATTORNEY MAY DO OR CAUSE TO BE DONE BY VIRTUE HEREOF. THIS POWER OF ATTORNEY SHALL BE IRREVOCABLE AND COUPLED WITH AN INTEREST. I (WE) ALSO AUTHORIZE AND DIRECT THE ABOVE NAMED INSURANCE COMPANY, AND/OR THE EMPLOYER OF THE ABOVE NAMED DECEASED INSURED, AND/OR ANY ORGANIZATION, AGENCY, ENTITY, OR PERSON, ACTING AS CARETAKER OF THE INFORMATION ABOUT THE POLICY(IES), BENEFICIARY(IES), AND ANY CLAIM(S) ON THE POLICY, TO GIVE AND RELEASE TO **UNITY FUNDING COMPANY, LLC** ANY AND ALL INFORMATION IT REQUESTS REGARDING THE POLICY(IES), BENEFICIARY(IES) AND CLAIM(S) ON THE POLICY. THE UNDERSIGNED HEREBY GRANTS **UNITY FUNDING COMPANY, LLC** PERMISSION TO OBTAIN FROM THE AFORESAID PARTY(IES) ALL PRIVACY ACT AND FREEDOM OF INFORMATION ACT INFORMATION REQUEST BY IT TO PROCESS ALL INSURANCE CLAIMS HEREUNDER, INCLUDING OBTAINING CERTIFIED COPIES OF THE DEATH CERTIFICATE FOR THE DECEASED INSURED. FOR VALUE RECEIVED, I/WE AGREE TO HOLD HARMLESS THE ABOVE-NAMED INSURANCE COMPANY AND/OR EMPLOYER FROM ANY AND ALL LIABILITY FROM ANY AND ALL LIABILITY TO ME/US WITH REGARD TO ITS/THEIR RELEASE OF INFORMATION TO **UNITY FUNDING COMPANY, LLC** ABOUT THE ABOVE LIFE INSURANCE CONTRACT/POLICY(IES)/POLICY BENEFITS AND BENEFICIARY DESIGNATION. EACH ASSIGNOR HEREIN DOES HEREBY ACKNOWLEDGE THAT HE/SHE DOES NOT RETAIN OR KEEP ANY CONTROL OVER THE FUNDS ASSIGNED TO THE FUNERAL HOME AND/OR CEMETERY, AND REASSIGNED TO **UNITY FUNDING COMPANY, LLC** AND THAT THE ABOVE SPECIFIED LIFE INSURANCE PROCEEDS ARE IRREVOCABLY ASSIGNED AND REASSIGNED TO **UNITY FUNDING COMPANY, LLC** FOR VALUE RECEIVED, THE RECEIPT OF WHICH IS HEREBY ACKNOWLEDGED BY THE UNDERSIGNED BENEFICIARY(IES). IN THE EVENT THAT THE LIFE INSURANCE PROCEEDS ARE ULTIMATELY DETERMINED BY THE ABOVE-NAMED INSURANCE COMPANY TO BE LESS THAN THE AMOUNT HEREIN ABOVE ASSIGNED, THEN, UPON NOTICE TO HIM/HER OF THE DEFICIT IN PROCEEDS, I/WE AGREE TO FORTHWITH REIMBURSE **UNITY FUNDING COMPANY, LLC** THE ENTIRE BALANCE USE HEREUNDER. EACH ASSIGNOR DOES HEREBY ACKNOWLEDGE THAT HE/SHE IS A U.S. CITIZEN, AT LEAST 18 YEARS OF AGE AND IS NOT SUBJECT TO ANY BACKUP WITHHOLDING BY THE IRS. **I (WE) AUTHORIZE UNITY FUNDING COMPANY, LLC, LLC AS MY POWER OF ATTORNEY TO COMPLETE, SIGN, AND ENDORSE ANY AND ALL CLAIM FORMS/CLAIMANT STATEMENTS REQUIRED TO COMPLETE ANY AND ALL CLAIM(S) ON THE ABOVE POLICY(IES) AND CLAIM(S) FOR THE ABOVE INSURANCE COMPANY INCLUDING FOR THE FULL PROCEEDS OF SAID POLICY(IES) AND CLAIM(S).**

1. Beneficiary Signature	Relationship	Date	2. Beneficiary Signature	Relationship	Date
3. Beneficiary Signature	Relationship	Date	4. Beneficiary Signature	Relationship	Date

THE FOREGOING IRREVOCABLE ASSIGNMENT WAS EXECUTED BY: _____, _____
PRINTED NAME OF BENEFICIARY PRINTED NAME OF BENEFICIARY
WHO IS PERSONALLY KNOWN TO ME OR PRODUCED IDENTIFICATION

PRINTED NAME OF BENEFICIARY PRINTED NAME OF BENEFICIARY

NOTARY PUBLIC SIGNATURE _____ **MY COMMISSION EXPIRES** _____ **NOTARY STAMP/SEAL** _____

Irrevocable Reassignment to UNITY FUNDING COMPANY, LLC

THE UNDERSIGNED IS ENTITLED TO RECEIVE BENEFITS OF POLICY(IES) ISSUED OR REINSURED BY _____ (INSURANCE COMPANY) ON THE LIFE OF _____ (DECEDENT)
AS A RESULT OF AN ASSIGNMENT OF LIFE INSURANCE PROCEEDS (ASSIGNMENT) BY THE BENEFICIARY(IES) OF THE FOLLOWING POLICY(IES)/CERTIFICATE(S):

IN THE AMOUNT OF \$ _____ (ASSIGNED AMOUNT) FOR PURPOSES OF PROVIDING GOODS AND SERVICES IN CONJUNCTION WITH THE DECEDENT'S FUNERAL AND/OR BURIAL. FOR VALUE RECEIVED, THE UNDERSIGNED DO HEREBY IRREVOCABLY ASSIGN, TRANSFER, CONVEY AND SET OVER UNTO **UNITY FUNDING COMPANY, LLC**, ITS SUCCESSORS AND ASSIGNS ALL OUR RIGHTS, TITLE, INTEREST, AND CLAIM TO THE ABOVE POLICY(IES)/CERTIFICATE(S), AND APPOINT **UNITY FUNDING COMPANY, LLC**, AS OUR ATTORNEY-IN-FACT, HEREBY RATIFYING AND CONFIRMING ALL THAT OUR SAID ATTORNEY MAY DO OR CAUSE TO BE DONE BY VIRTUE HEREOF. THIS POWER OF ATTORNEY SHALL BE IRREVOCABLE AND COUPLED WITH AN INTEREST. I ALSO DIRECT THAT PAYMENT BE MADE DIRECTLY AND SOLELY TO **UNITY FUNDING COMPANY, LLC**. IN THE EVENT THAT ANY PAYMENTS OF PROCEEDS ARE MADE BY THE INSURANCE COMPANY, OR IT'S AGENT, TO ME, ERRONEOUSLY, SUBSEQUENT TO THE EXECUTION OF THIS REASSIGNMENT TO **UNITY FUNDING COMPANY, LLC**, THEN I AGREE TO IMMEDIATELY PAY THE PROCEEDS TO **UNITY FUNDING COMPANY, LLC**. IN CASES OF FRAUD OR MISREPRESENTATION, FAILURE TO REALIZE THE PROCEEDS ASSIGNED BY THE BENEFICIARIES IN THE FULL AMOUNT ASSIGNED FOR THE LIFE INSURANCE POLICY(IES) SHALL NOT RELIEVE THE UNDERSIGNED TO PAY THE FULL AMOUNT, OR THE UNPAID BALANCE OF THE FULL AMOUNT. IN THE EVENT THAT ALL REQUIRED DOCUMENTATION IS NOT RECEIVED BY **UNITY FUNDING COMPANY, LLC** WITHIN 90 DAYS OF THIS REASSIGNMENT ("DUE DATE"), THEN THE UNDERSIGNED FUNERAL HOME AND/OR CEMETERY, HEREBY UNCONDITIONALLY AND IRREVOCABLY, GUARANTEES TO FULLY AND PROMPTLY REIMBURSE **UNITY FUNDING COMPANY, LLC** THE UNPAID AMOUNT OF THE REASSIGNED BENEFITS IMMEDIATELY UPON DEMAND WITHOUT RESORT BY **UNITY FUNDING COMPANY, LLC** TO ANY PERSON OR PARTY. IF THE ASSIGNED AMOUNT IS NOT PAID IN FULL, DUE TO INCOMPLETE DOCUMENTATION, WITHIN 120 DAYS OF THIS ASSIGNMENT, THEN INTEREST SHALL BE DUE AND PAYABLE ON THE REMAINING PRINCIPAL BALANCE, CALCULATED RETROACTIVELY FROM THE DATE OF ENTERING THIS NOTE AT THE RATE OF 12% PER ANNUM, OR THE MAXIMUM RATE OF INTEREST PERMITTED BY LAW NOT EXCEEDING 12% PER ANNUM, UNTIL THE PRINCIPAL AMOUNT IS PAID IN FULL. THE FUNERAL HOME AND/OR CEMETERY AGREE TO PAY ANY AND ALL EXPENSES, INCLUDING REASONABLE ATTORNEY FEES AND LEGAL EXPENSES PAID OR INCURRED BY **UNITY FUNDING COMPANY, LLC** IN PROTECTING AND ENFORCING ITS RIGHTS UNDER ANY PROVISION OF THIS IRREVOCABLE REASSIGNMENT. ON BEHALF OF MYSELF/OURSELVES AND THE FUNERAL HOME AND/OR CEMETERY. I/WE AGREE THAT OHIO SHALL BE THE EXCLUSIVE JURISDICTION AND VENUE FOR LEGAL PROCEEDING HEREUNDER. IN THE EVENT ANY PROVISIONS OF THIS IRREVOCABLE ASSIGNMENT SHALL BE FOUND NULL, VOID, UNLAWFUL OR OTHERWISE UNENFORCEABLE, THEN THAT PROVISION SHALL BE DEEMED TO BE SEVERED FROM THIS IRREVOCABLE ASSIGNMENT AND THE REMAINDER SHALL BE ENFORCEABLE.

FUNERAL HOME/CEMETERY _____ BY _____ DATE _____
AUTHORIZED SIGNATORY OF FUNERAL HOME/CEMETERY

THE FOREGOING IRREVOCABLE REASSIGNMENT WAS EXECUTED BY _____ WHO IS PERSONALLY KNOWN TO ME OR PRODUCED IDENTIFICATION.
PRINT NAME OF AUTHORIZED SIGNATORY

NOTARY PUBLIC SIGNATURE _____ **MY COMMISSION EXPIRES** _____ **NOTARY STAMP/SEAL** _____