OFFICE USE ONLY
CLAIM NUMBER:

DEPARTMENT OF FINANCIAL SERVICES
Division of Funeral, Cemetery, and Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0361

PRENEED CLAIM – FORM A

For use by Funeral Establishments & Other Deathcare Service Providers
Under Section 497.456, F.S.

READ THE FOLLOWING CAREFULLY: This form is for use by an at-need deathcare service provider who has provided deathcare goods or services for a deceased who was a Beneficiary under a preneed contract and the seller of the preneed contract has defaulted or is no longer in business. The Assignments of Rights, Form DFS-AOR-1, must accompany this claim form.

As used in this application: "At-need contract" refers to a contract for funeral, cremation, burial, or related services and merchandise, purchased at or after the time of death; "At-need provider" refers to a funeral home, cremation service, cemetery, or other provider which provides services pursuant to a contract or agreement entered into at or after the time of death; "Beneficiary" refers to the decedent, whose death and funeral or other final arrangements were the subject of the preneed contract; "Board" refers to the Board of Funeral, Cemetery, and Consumer Services; "Claimant" is the purchaser seeking refund submitting this claim. "Division" is the Division of Funeral, Cemetery, and Consumer Services; "F.S." refers to Florida Statutes; "Purchaser" refers to the person who paid for the preneed contract and the owner of the rights under the contract. The purchaser and beneficiary may be the same person; however, an adult child or other family member or another person may separately pay for the preneed contract.

USE INK AND PRINT CLEARLY. Answer all applicable questions – if any answer is illegible, or the form is incomplete, it will delay processing this claim form or require submission of another claim form.

Section 1. CLAIMANT INFORMATION

1A. Claimant's full legal name: _____

1B. Claimant's street address: _____

_____

1C. Claimant's phone number with area code: _____

1D. Claimant's email address: _____

1E. Claimant's state license number: _____

Section 2. CLAIMANT'S AUTHORITY

Are you, the claimant, aware of any person(s) or entities who is or would dispute your authority and standing to file this claim and or receive payment under this claim? **YES** **NO**

Section 3. BENEFICIARY INFORMATION

3A. Beneficiary's name: _____

3B. Place of death (county and state): _____

3C. Date of death: _____

Section 4. PRENEED CONTRACT AND PAYMENTS INFORMATION

Enter the following information about the firm who issued the preneed contract & has failed to fulfill the preneed contract.

4A. Name of firm:

4B. Date of preneed contract which is the subject of this claim:

4C. Total price of the preneed contract:

4D. Preneed contract number:

4E. Who paid for the preneed contract?

Beneficiary

Other, **answer the following:**

Name:

Address:

Relationship to Beneficiary:

4F. How was payment for the preneed contract made?

Cash

Check(s)

Credit card

Automatic bank account debits

Other as follows:

4G. Was payment made for the preneed contract made in a single lump sum or in installment payments?

Single lump sum

Installment payments

4G. What is the total amount you can prove was actually paid for the preneed contract (with canceled checks, receipts, or other documentation)**? $**

4H. Were any portion of payments for the preneed contract put into a trust?

Do not know

No

Yes, **answer the following:**

4H1. Name of the trust company or trust servicing agent:

4H2. Address of the trust company or trust servicing agent:

4H3. How much was put into the trust? $

4H4. Have trust funds been paid out to a Beneficiary, Purchaser, At-need provider, or any other person?

YES NO

If YES, how much has been paid out? $

4I. Were any goods or merchandise delivered by the original preneed contract seller, to the Beneficiary or Purchaser, under the preneed contract? (e.g. urn, casket, etc.) YES NO

If YES, identify the items: _____

_____ **4J. Have any refunds or cancellation funds at any time been paid to Beneficiary or Purchaser concerning the preneed contract? YES NO**

If YES, how much: $ _____

4K. Was the preneed contract funded in whole or part by a life insurance policy? YES NO

If YES, answer the following:

Name of life insurance company: _____

Policy number: _____

Have any proceeds been paid by the life insurance company:

YES NO DO NOT KNOW

4L. Have all goods and services promised under the preneed contract been provided by you?

YES NO

If NO, state what goods and services you have not provided:

_____

_

_____

_

Section 5. AT-NEED SERVICES PROVIDED

5A. Total price you charged for all at-need goods and services for the Beneficiary:

$ _____

5B. Of the total amount stated in 5A., how much is attributable to goods and serves that were to be provided under the preneed contract?:

$ _____

5C. Total amount actually paid to you for your at-need goods and services from any source:

$ _____

5D. Total amount actually paid to you for goods and services associated with the Beneficiary:

$ _____

5E. Provide the following information of the Family Representative your firm primarily interacted with for information, instructions, and authorizations concerning at-need goods and services relating to the final disposition of the Beneficiary's remains.

5E1. Name: _____

5E2. Address: _____

5E3. Phone number: _____

5E4. Relationship to the Beneficiary:

Spouse Adult Child Brother or sister Parent Grandchild

Other as follows: _____

5F. Provide the following information of the person who signed the at-need contract regarding the Beneficiary.

Check if the signer is the same person as the Family Representative.

5F1. Name:

5F2. Address:

5F3. Phone number:

5F4. Relationship to the Beneficiary:

Spouse Adult Child Brother or sister Parent Grandchild

Other as follows:

5G. Were any of the at-need services you are claiming for provided by another licensee? (e.g. removal service; cremation service; etc.)

YES NO

5G1. Have all such licensees been paid in full? YES NO

5G2. Provide the following information of the licensees involved in the at-need services (Attach additional pages if necessary):

5G2a. Name:

5G2b. Address:

5G2c. Phone number:

5H. Have all the goods and services you are claiming for been provided and completed?

YES NO

If **NO,** specify what goods and/or services have not been provided or completed:

Section 6. AMOUNT OF CLAIM

State the amount you are claiming: $

Section 7. FEIN OR SOCIAL SECURITY NUMBER

Enter Claimant's FEIN or Social Security Number:

Purpose and Use:

Pursuant to the Privacy Act of 1974, 5 U.S.C. Section 552a, the State is responsible for informing you whether disclosure of your social security number is mandatory or voluntary, by what statutory or other authority your social security number is solicited, and what uses will be made of your social security number. Under section 119.071(5)(a)2., F.S., a state agency may collect your social security number if the collection is specifically authorized by law or if it is imperative for the performance of the agency's duties and responsibilities as prescribed by law. Disclosure of your social security number on this form is: mandatory pursuant to 26 USC 6109, and will be used for purposes of complying with filing requirements imposed by the U.S. Dept of Treasury, Internal Revenue Service. All payments made on approved Consumer Protection Trust Fund claims will be reported to the U.S. Dept of Treasury, Internal Revenue Service. Your social security number is confidential and exempt from the disclosure requirements of section 119.07(1), F.S., and section 24(a), Article I of the Florida Constitution and will not be used for any purpose other than the purpose(s) provided herein, or as otherwise authorized under section 119.071(5)(a), F.S.

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Section 8. CLAIMANT SIGNATURE	
Pursuant to Section 497.159, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license, with intent to mislead the board or a public employee in the performance of her or his official duties, or the act of attempting to obtain or obtaining a license by knowingly misleading statements or knowing misrepresentations, constitutes a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Under penalties of perjury, I declare that I have read the foregoing claim form and that the facts stated in it are true to the best of my knowledge and belief. _____ Signature of Claimant _____ Print Name of Claimant	_____ Date Signed
NOTARY ACKNOWLEDGEMENT	
STATE OF: _____ COUNTY OF: _____	The foregoing instrument was acknowledged before me this: _____ day of _____, by: _____.
☐Personally Known OR ☐Produced Identification	_____ *Type of Identification Produced*
[NOTARY SEAL]	_____ *Signature of Notary Public* _____ *Name of Notary Public*

Attachments and Submission

Attach to this claim the following:

1. Assignment of Rights, Form DFS-AOR-1.
2. Preneed contract completed, legible, signed, and dated.
3. Preneed contract amendments or addendum signed and dated.
4. Proof of amount paid for the preneed contract (i.e. copies of canceled checks (front and back), or receipts issued by the seller of the preneed contract).
5. Original certified death certificate of the Beneficiary with the original embossed seal or colored stamp or signature of the issuing counter.
6. At-need contract with the items and services purchased, the purchase prices of those items and services, the contact information of the licensee, the signatures of the customer and licensee, and the date signed.
7. Proof of amount paid for the at-need contract.

Mail the completed claim and required attachments to:
Division of Funeral, Cemetery, and Consumer Services
ATTN: Preneed Claims
200 East Gaines Street
Tallahassee, FL 32399-0361