Claims Service Center
P.O. Box 45153
Jacksonville, FL 32232-5153
1.800.888.2738, Ext. 8390
Fax: 1.904.355.5878
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CREDIT DISABILITY / DISMEMBERMENT / LOSS OF SIGHT CLAIM

- ❑ Credit Disability
- ❑ Dismemberment
- ❑ Loss of Sight

CREDIT INSURANCE COMPANY

- ❑ American Republic Insurance Company
- ❑ Life of the South Insurance Company
- ❑ Bankers Life of Louisiana
- ❑ Southern Financial Insurance Company
- ❑ ________________________________

To avoid delay, all questions must be answered and a copy of the Insurance certificate and loan agreement must be attached.

CREDITOR'S

1. Claimant's Name	Loan Number	Certificate Number

2. Issue Date	Payment Amount	First Payment Due Date	Maturity Date	Waiting Period	# of Payments Made
				❑ Elimination _______ Days ❑ Retroactive _______ Days	

3. Is this a renewal loan? ❑ Yes ❑ No If yes, provide original loan date ________________ If no, provide previous carrier ______________________________

4. Has coverage been continuous with our company? ❑ Yes ❑ No Loan Number

5 Name of Creditor	Address	City	State	Zip	Telephone Number

6. I hereby certify the information provided is true and complete to the best of my knowledge and belief. Signed on behalf of Creditor by:
Print Name ____ Signature ____ Date

INSURED'S

1. Full Name of Claimant	Telephone Number	Social Security Number	Date of Birth

2. Address	City	State	Zip

3. Email Address	Average hours worked per week	Occupation

4. Name of Employer	Telephone Number

Address	City	State	Zip

5. Date you became unable to work | Date you expect to return to work: light work ____________ full time work ____________ | Have you ever had this or a similar condition before? ❑ Yes ❑ No If yes, give date ______________________________

6. **Accident Claims Only** Injury Occurred: Date _________________ Time___________ ❑ AM ❑ PM | Were you injured at work? ❑ Yes ❑ No | Are you still working ? ❑ Yes ❑ No

7. Briefly describe nature of accident and resulting injury:

8. Were you hospital confined? ❑ Yes ❑ No	Date admitted	Date released	Name of Hospital

Address	City	State	Zip	Telephone Number

9. Provide names, addresses and telephone numbers of all physicians you have seen in the 2 years prior to this loan. **Use additional paper if needed.**

Physician Name	Address	City	State	Zip	Telephone Number
Physician Name	Address	City	State	Zip	Telephone Number

AUTHORIZATION: Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide my credit insurance company named above or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the Claimant named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide my insurance company with financial or employment-related information.

I understand that such information will be used by the insurance company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the term of the policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

I also hereby certify that I have read and understand the attached Fraud Warning Statement.

Date: _______________________ Signature of Claimant: ____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for all expenses incurred in the completion of this Form.

PATIENT'S NAME — DATE OF BIRTH

1. HISTORY
   (a) Date you advised patient to cease work? MO ____________ DAY ____________ YR ____________
   (b) Has patient ever had same or similar condition? YES ❑ NO ❑ **If yes, state when and describe:** ____
   (c) Is this the result of an accident? YES ❑ NO ❑ **If yes, describe:** ____
   (d) Referring Physician Information, if referred:

   NAME ____________ TELEPHONE NUMBER ____________ EMAIL ADDRESS ____________

   ADDRESS ____________ CITY ____________ STATE ____________ ZIP ____________

2. DIAGNOSIS **(ICD Code Required)**

3. TREATMENT
   (a) Date of first visit for this condition MO _______ DAY _______ YR _______
   (b) Date of most recent visit MO _______ DAY _______ YR _______
   (c) Frequency of visits ❑ WEEKLY ❑ MONTHLY ❑ OTHER ____________________
   (d) Next appointment date MO _______ DAY _______ YR _______

4. EXTENT OF DISABILITY (condition)
   (a) Is Patient able to perform the duties of their current occupation? ❑ YES ❑ NO
   (b) Is Patient able to perform the duties of any occupation? ❑ YES ❑ NO
   (c) Is this condition permanent? ❑ YES ❑ NO ____________________
   (d) Provide dates patient was unable to perform the duties of their current occupation. FROM MO ______ DAY ______ YR ______ TO MO ______ DAY ______ YR ______
   (e) If able to return to work, provide date patient was released back to work. MO ______ DAY ______ YR ______
   (f) Was patient released with or without restrictions? ❑ without restrictions ❑ with restrictions
   (g) If there are restrictions, **please list:** ____

5. Is condition due to complications during Pregnancy? YES ❑ NO ❑ **If yes, list complications:** ____

6. Provide expected or actual delivery date MO ____________ DAY ____________ YR ____________

7. NAME OF ATTENDING PHYSICIAN (Please Print) ____________ TAX I.D. # ____________ TELEPHONE NUMBER ____________

   ADDRESS ____________ CITY ____________ STATE ____________ ZIP ____________

SIGNATURE OF ATTENDING PHYSICIAN — DATE

(ALL CLAIMS SHOULD BE FILED THROUGH THE CREDITOR)

EMPLOYER'S STATEMENT

1. Employee's Name	Job title and occupation	Average hours worked weekly

2. Date employed	Date last worked	Last day employee worked full time? Date ___	Is this claim one that may be covered by Worker's Compensation? ❑ Yes ❑ No
3. Are they still employed? ❑ Yes ❑ No	Were they laid off? ❑ Yes ❑ No	Was leave of absence granted? ❑ Yes ❑ No	When did leave start, layoff start or employment terminate? Date ___

4. When did employee become unable to perform the duties of their current position? Date ___

5. Has the employee returned to work? ❑ Yes ❑ No **If no, skip to question 10.**

6. If yes, was return without restrictions or with restrictions? ❑ without restrictions ❑ with restrictions

7. Provide the current average weekly hours now being worked. ________

8. If return was with restrictions were you the employer able to accommodate? ❑ Yes ❑ No

9. Have these restrictions affected the employee's compensation? ❑ Yes ❑ No **If yes, explain:** ___

10. When do you expect the employee to return to work? Date ___

11. Employer's Name			
Address	City	State	Zip
Email Address	Telephone Number		

I hereby certify to the best of my knowledge and belief all the answers given by the Employer and by me are true and complete.

Signed on behalf of employer by:

Name of Signee (Please Print)	Email Address	Date
Signature	Title or Position	Telephone Number

(ALL CLAIMS SHOULD BE FILED THROUGH THE CREDITOR)

STATE SPECIFIC FRAUD WARNINGS

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under this title.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas and New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware and Idaho Residents: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of a claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia and Washington DC Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and a denial of insurance benefits.

Maine Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota Residents: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. §638:20.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact may be guilty of an insurance fraud, which is a crime, and may be subject to prosecution.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas, West Virginia and Alabama Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison, or any combination thereof.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.