CREDIT DISABILITY CLAIM FOR FINANCE

PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM

Claims Service Center
P.O. Box 45153
Jacksonville, FL 32232-5153
1-800-888-2738, Ext. 8390

This form must be completed in full and FAXED to (904) 355-5878

CREDIT INSURANCE COMPANY

- ☐ American Republic Insurance Company
- ☐ Life of the South Insurance Company
- ☐ Protective Life Insurance Company
- ☐ Bankers Life of Louisiana
- ☐ Triangle Life Insurance Company
- ☐ _____

CREDITOR'S

1. Claimant's Name			Loan Number	Certificate Number
2. Issue Date	Amount	First Payment Due	Waiting Period	# of Payments Made
			☐ Elimination _____ Days ☐ Retroactive _____ Days	
3. How Payable _____ Mos @ $ _____		4. Is there other insurance on this or other notes with your company? ☐ Yes ☐ No Is this a renewal loan? ☐ Yes ☐ No		If Yes, how many loans? _____
5. Dealer Name		City		State Zip
6. Name of Creditor Payee		Address	City State Zip	Telephone #
7. Mail Check to the Attention of:		Is a copy of the insurance Certificate attached? ☐ Yes ☐ No If no, explain:		
8. I hereby certify that the above answers are true and complete to the best of my knowledge and belief. Signed on behalf of Creditor by:				Date

See State Specific Fraud Warnings attached.

INSURED'S

Full Name of Claimant			Telephone Number	Social Security Nunmber	Date of Birth
Street Address	City		State	Zip Code	
Email Address	Name and Address of Your Employer				
Describe the activities required to perform your job.		Average hours worked per week	Base Pay ☐ Hour ☐ Month $ _____ ☐ Week ☐ Year		
Date you became totally disabled (unable to do any 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 _____			
Accident Claims Only Date and Time Injury Occurred: _____ ☐ AM ☐ PM	Were you injured at work? ☐ Yes ☐ No	Briefly Describe how, when, where and why this injury incurred.			
Were you hospital confined? ☐ Yes ☐ No Date Admitted: _____	Name and Address of the Hospital _____ City _____ State _____ Zip _____				
Have you performed any work other than your usual occupation? ☐ Yes ☐ No If "yes," give nature of work and dates worked.	Are you receiving or entitled to receive any other disability benefits? ☐ Yes ☐ No Source _____ Amount _____				
Give names and addresses of all doctors treating your present disability.					
Give names and addresses of all doctors you have seen in the 2 years prior to this loan.					
Give name and address of your family physician.					
Give name, address, telephone number and policy number of your Health Insurance Provider for the past 3 years.					

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.

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

Date: _____ Signature of Claimant: _____

ALL QUESTIONS MUST BE FULLY ANSWERED TO AVOID DELAY IN PROCESSING THIS CLAIM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form without expense to the Company.

NAME OF PATIENT

DATE OF BIRTH

1. HISTORY
   (a) Date patient ceased work because of disability? MO. _____ DAY _____ , _____
   (b) Date symptoms first appeared or accident occurred? MO. _____ DAY _____ , _____
   (c) Has patient ever had same or similar condition? YES ☐ NO ☐ If yes, state when and describe.
   _____
   (d) Name and address of referring physician _____
   (e) What other physicians have treated the patient?

2. PRESENT CONDITION Is Patient Ambulatory? ☐ Bed Confined? ☐ House Confined? ☐ Hospital Confined? ☐
   Subjective Symptoms _____
   Objective Findings _____
   Include results of current X-rays, EKG's or any other special tests.

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

4. TREATMENT
   (a) Date of first visit for this condition MO. _____ DAY _____ , _____
   (b) Date of last visit MO. _____ DAY _____ , _____
   (c) Frequency of visits WEEKLY ☐ MONTHLY ☐ OTHER _____
   (d) Next appointment date

5. PROGRESS RECOVERED ☐ IMPROVED ☐ UNIMPROVED ☐ RETROGRESSED ☐

6. EXTENT OF DISABILITY

	FOR ANY OCCUPATION	FOR REGULAR OCCUPATION
(a) Is Patient now totally disabled?	YES ☐ NO ☐	YES ☐ NO ☐
(b) If no, when was patient able to go to work?	MO. _____ DAY _____ , _____	MO. _____ DAY _____ , _____
(c) If yes, provide dates Patient was totally disabled from work?	FROM ___/___/___	TO ___/___/___
If release date not given, approximate date: _____	Release Date: ☐ less than 3 months ☐ 3 to 6 months ☐ Never	
(d) If yes, is Patient suitable candidate for a rehabilitation program?	YES ☐ NO ☐	
(e) Are there any complications which would prolong disability? Describe Complications:	YES ☐ NO ☐	

7. CARDIAC (if appropriate)
   (a) Functional Capacity (American Heart Association) CLASS 1 (No Limitation) ☐ CLASS 2 (Slight Limitation) ☐
   (b) Blood Pressure CLASS 3 (Marked Limitation) ☐ CLASS 4 (Complete Limitation) ☐

8. Is condition due to injury or sickness arising out of patient's employment? YES ☐ NO ☐ Pregnancy? YES ☐ NO ☐ If yes, approximate date pregnancy commenced. Date _____ E.D.C. _____

DATE	SIGNATURE OF ATTENDING PHYSICIAN	NAME (Please Print)	TAX I.D. #	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE	ZIP

EMPLOYER'S

1. Employee's Name		Job title and duties		Hours Worked Weekly
2. Date Employed	Date last worked	Last week employee worked 30 or more hours? 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. Date employee became totally disabled to work. _____ Date employee returned to light work _____ Date employee returned to full time work _____			If not returned to work, do you expect employee to return? ☐ YES ☐ NO When? _____	
5. Employer's name and mailing address (If self employed, give name and address of place of business)			To the best of my knowledge and belief that all of the answers given by the employee and by me are true and complete. Signed on behalf of employer by	
6. Date	Title or Position		Telephone Number	

(ALL CLAIMS SHOULD BE FILED THROUGH THE CREDITOR)

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 fines and confinement in prison.

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 state law.

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 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 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 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 or 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 and West Virginia 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.

Detach here and give this side to the customer.