

## **Initial Credit Disability Claim Form**

### **GUARANTEE TRUST LIFE INSURANCE COMPANY**

Credit Claim Service Center  
P.O. Box 1145  
Glenview, IL 60025  
Phone: 800-592-0629  
Fax: 847-460-2962

#### Office Hours:

7:00 A.M. to 5:00 P.M CST Monday thru Thursday  
Friday: 8:00 A.M. to Noon CST

### **Important Information**

To speed processing of your claim, please attach a copy of your insurance certificate and be sure your claim form is sent to the Credit Claim Service Center after you've completed **all four (4) sections**. Incomplete data or missing signatures will delay processing your claim.

### **FAQS**

#### ***Q. What do I send to get my claim started?***

**A.** You need to complete the claim form accurately paying special attention to:

- Section 1: In this section, give us as much information as you can about your loan. Since we'll be sending benefits to your creditor, we need their current address and especially the loan number so they can apply the money to the right account.
- Section 2: In this section, answer every question even if you don't think it's important. If not applicable, show N/A so we know you didn't overlook the question.
- Authorization Page: Be sure to sign it after you've completed the claim form. Keep it with your claim form so your physician and employer know we have your permission for them to answer our questions.

Please send the completed claim form to our mailing address shown above. We'll take care of everything when we get it.

(Please see the reverse side for additional information.)

***Q. When will my benefits begin? Should I continue to make payments?***

***A.*** Your loan agreement with your creditor is separate from your contract with us. There are many factors we don't control particularly how long it takes to get the requested proofs of loss. While we try our best to schedule payments to coincide with your loan due date, that's not always possible. It's your responsibility to keep payments current to avoid late charges or other penalties that your contract with us doesn't cover.

***Q. What if my physician wants to charge me for completing these forms?***

***A.*** The claim form is your proof of loss and must be provided to us without charge for us to evaluate your claim and authorize payments. Any payment the physician requires is your responsibility.

***Q. What about continuing the benefits?***

***A.*** Your policy says you must be under the regular care of a physician for benefits to continue. We'll let you know with each payment what we need for the next one. It's usually a shorter form for you and your doctor to complete. We'll also tell you the date we need to have the completed form. It's important to have your form completed by the doctor as close to this date as possible.

***Q. Are my benefits reduced if I am also collecting benefits from Workers Comp or Social Security Disability?***

***A.*** No. Your benefits are not related or limited by other coverage or payments made by Workers Compensation or Social Security Disability.

**Section 3****EMPLOYER'S STATEMENT**

1. Employee's Name: \_\_\_\_\_ 2. Date Employed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 3. Date Employee last worked: \_\_\_\_/\_\_\_\_/\_\_\_\_ 4. Reason employee left work: \_\_\_\_\_  
 5. Is this a Worker's Compensation case? Yes  No   
 Initial date of Worker's Comp. Illness or Injury \_\_\_\_/\_\_\_\_/\_\_\_\_  
 6. Has Employee been off work due to this same condition before? Yes  No   
 If "Yes," When? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 7. Job duties of Employee: \_\_\_\_\_ Classification: Light  Medium  Heavy  
 8. Has Employee returned to work with you? Yes  No  If "Yes," date returned \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Do you have a position when he/she is released? Yes  No   
 If Employee has been terminated, give date \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER NAME

STREET ADDRESS

CITY

ST

ZIP

AREA CODE &amp; PHONE

DATE SIGNED \_\_\_\_/\_\_\_\_/\_\_\_\_ CERTIFIED BY \_\_\_\_\_ TITLE \_\_\_\_\_

**Section 4****ATTENDING PHYSICIAN'S STATEMENT**

Patient's Name: \_\_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Primary medical condition causing current disability: \_\_\_\_\_  
 Describe complications, or indicate any contributing infirmities: \_\_\_\_\_  
 2. When did symptoms first appear or accident happen: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2a. If pregnancy is causing disability is pregnancy classed as: Normal  Abnormal   
 If "Abnormal" please give date disability began: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 3. When did patient first consult you for this condition? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 First date as patient: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 4. Was this patient referred to you by another physician? Yes  No   
 If "Yes," please give physician's name and address: \_\_\_\_\_  
 5. List all dates of treatment for this condition: Office: \_\_\_\_\_  
 Hospital: \_\_\_\_\_ Surgery: \_\_\_\_\_  
 6. List all dates and names of medication prescribed for this condition before and after disability inception: \_\_\_\_\_  
 7. Has patient ever been disabled or treated for same or similar condition?  
 Disabled  Treated   
 Yes  No  Yes  No  Description and date: \_\_\_\_\_  
 Ongoing: Yes  No  Separate/Unrelated: Yes  No   
 8. Is patient still under your care for this condition? Yes  No  If discharged, give date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 8a. Have you referred this patient to another physician? Yes  No   
 If "Yes," please give physician's name and address: \_\_\_\_\_  
 8b. Give patient's primary care physician's name and address: \_\_\_\_\_  
 9. As a result of your personal treatment of this patient during what period do you consider the patient to be totally and continuously disabled/restricted:  
 Disabled/Restricted from own occupation From: \_\_\_\_\_ To: \_\_\_\_\_  
 Disabled from other occupations: From: \_\_\_\_\_ To: \_\_\_\_\_  
 10. Remarks: \_\_\_\_\_  
 11. Actual release to return to work date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 With restrictions  Without restrictions   
 12. Estimated return to work:  Less than 6 months  6 to 12 months  12 or more months  Never

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Attending Physician's Signature: \_\_\_\_\_

Physician's Name typed or printed: \_\_\_\_\_ Degree: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Phone Number: \_\_\_\_\_



**Guarantee Trust Life Insurance Company**  
**P.O. Box 1145**  
**Attn: Credit Claim Department**  
**Glenview, Illinois 60025 800-592-0629**

**FOR GTL USE ONLY**

CLAIM #: \_\_\_\_\_

**Section 1** **COVERAGE AND CREDITOR STATEMENT**  
**PLEASE ATTACH A COPY OF YOUR INSURANCE CERTIFICATE**

Named Insured (Claimant) _____	Insurance Certificate Policy # _____	Monthly Payment Due Date ____/____/____
Certificate Information	Effective Date ____/____/____	Monthly Benefit \$ _____
	Term (Months) _____	Expiration Date ____/____/____
		<b>YOUR LOAN ACCOUNT NUMBER</b> _____

Creditor/Mortgagor (Lending Institution) \_\_\_\_\_  
 Address \_\_\_\_\_  

Street or PO Box
City
State
Zip Code
Phone Number

**Reminder: Incomplete data will delay your claim.**

**Section 2** **STATEMENT OF THE INSURED**

**Please complete all of the questions, sign and date authorization.**

1. Employer's Name: \_\_\_\_\_ 1a. Address: \_\_\_\_\_
2. Date you last worked: \_\_\_\_/\_\_\_\_/\_\_\_\_ 2a. YOUR occupation at time of disability? \_\_\_\_\_
- 2b. YOUR job duties at time of disability were? \_\_\_\_\_
3. Describe MEDICAL CONDITION causing disability: \_\_\_\_\_
- 3a. When were symptoms FIRST noticed: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3b. Is your condition due to an accident?  Yes  No
- 3c. Is your illness or accident WORK RELATED?  Yes  No  
 If "Yes," indicate initial illness or accident date: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Have you ever been TREATED or DISABLED by a same or similar condition before?  Yes  No  

Physician's Name: _____	Physician's Name: _____
Physician's Address: _____	Physician's Address: _____
Physician's city, state & zip: _____	Physician's city, state & zip: _____
Physician's treatment dates: From: ____ To: ____	Physician's treatment dates: From: ____ To: ____
5. PRIMARY CARE PHYSICIAN Name: \_\_\_\_\_ Address: \_\_\_\_\_
6. A. If hospitalized, give dates A. From: \_\_\_\_ To: \_\_\_\_ A. From: \_\_\_\_ To: \_\_\_\_  
 B. Name of each hospital B. \_\_\_\_\_ B. \_\_\_\_\_  
 C. Hospital Address C. \_\_\_\_\_ C. \_\_\_\_\_
7. Date you became TOTALLY DISABLED (Unable to work) \_\_\_\_/\_\_\_\_/\_\_\_\_
8. Have you RETURNED OR BEEN RELEASED TO RETURN TO WORK?  Yes  No  
 If "Yes," give DATE RETURNED TO WORK. \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please be sure to sign the authorization on Page 3 before taking to your employer and physician.**