

Administrative Office
400 Galleria Parkway, Suite 1000
Atlanta, GA 30339
Tel 1-800-846-8039

Life Investors Insurance Company of America

Attach a copy of certificate schedule or payment coupons, if available.

Mail To:
PO Box 420857
Atlanta, GA 30342-0857

Notice Of Disability Claim

A. Creditor - Your creditor or lien holder should complete this section

Creditor's Name:

Creditor's Complete Address:

Loan
Number:

Dealer Name:

Certificate/Policy Number:

Effective Date:

Term:

Monthly Benefit Amount: \$

APR:

Type of Loan:

Open End

Closed End

Credit Card

Outstanding Balance at Time of Disability: \$

Creditor/Agent Signature:

Date:

Phone #:

B. Claimant - You complete this part then take form to doctor to be completed and mailed

Full Name:

Sex: Male
 Female

Street
Address:

City/State/Zip:

Phone
Number:

Social
Security No.:

Birth
Date:

Are you
self-employed? Yes
 No

Employer Name:

Occupation:

Employer
Street Address:

City/State/Zip:

Describe illness or injury*:

Date of First Symptoms:

Date of First Treatment:

If Caused by Accident, Describe Briefly:

Date:

Place (Home, Work, Other):

*If injury due to motor vehicle accident, please attach copy of police report.

Name of
Attending Physician:

Street Address
City/State/Zip:

Name of Your
Family Doctor:

Street Address
City/State/Zip:

Name(s) and Address(es) of the Hospital(s) Where You Were Confined During The Past Two Years (Indicate Dates Of Admission):

Name of all Physicians
consulted in Past 5 years:

Street Address
City/State/Zip/Telephone number:

(Indicate Specialty)

Dates of Total Disability

Date You Last Worked

Date You Became Totally Disabled

FROM:

TO:

Date You Were First Able to Return to Light Work:

If you Have Not Returned Because of
Continuing Disability, Give Date You
Expect to be Able To Return to Work:

D. Doctor Statement

Name of Patient:

Patient ID Number:

Diagnosis:

Nature and cause of injury or condition:

When did patient first consult you for this condition? Date:

List all names, addresses and telephone numbers of other treating physicians.

If due to injury, is condition described as: New Injury Recurrence Has patient ever had same or similar condition? Yes No If yes, when?

Is condition due to pregnancy? Yes No LMP Date:

If yes, are there any complications? Yes No Please Describe:

Dates of Treatment for this medical condition:

Surgical procedure, if any:

Name and address of hospital, if hospitalized:

Date admitted:

Date discharged:

How long was or will patient be continuously totally disabled (unable to work)? Must have beginning date. From:

To:

Prognosis:

When did patient return to his/her regular occupation?

When did patient return to any occupation?

When will patient be able to return to his/her occupation?

Any occupation?

If treatment terminated, on what date?

If so, why?

Limitations/Restrictions:

How long will they be in effect?

Print Physician's Name:

Date:

Physician's Signature:

Date:

Name of Attending Physician:

Street Address
City/State/Zip:

Phone #:
Fax #:

AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL INFORMATION

To: Life Investors Insurance Company of America ("Insurer")

I hereby give Insurer permission to obtain use and/or disclose the insured/claimant's personal health information as follows:

- This authorization was prepared at the request of Insurer for the purpose of evaluating contestability and eligibility for benefits.
- The information that is the subject of this authorization and which will be used or disclosed as set forth below includes the release of **all medical records** including (except psychotherapy notes), including, but not limited to, those containing medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse, or information regarding communicable or infectious conditions, such as AIDS.
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose my personal health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical record retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Insurer in reliance on this authorization, by sending a written revocation to: Life Investors Insurance Company of America, 1100 Johnson Ferry Road, Suite 300, Atlanta, Georgia, 30342.
- I understand that I am not required to sign this authorization form and that Insurer will not condition the provision of payment to me on the signing of this authorization, except that Insurer may condition evaluating contestability or insurance coverage eligibility for benefits on provision of this authorization if the authorization sought is for insurance coverage contestability evaluation or insurance coverage eligibility relating to the insured. This authorization will expire 24 months from the date this authorization is signed.

Insured/Claimant Name (Print)

Signature of Insured/Claimant or
for Life Claim the Authorized Representative

Date

Insured or Authorized Representative: Sign this form and return with the claim form to:
1100 Johnson Ferry Road, Suite 300
Atlanta, Georgia 30342

Please keep a copy of this form for your records.