

# CREDIT DISABILITY CLAIM

## Credit Insurance Processing Center

100 West Bay Street / P.O. Box 45204  
 Jacksonville, FL 32232-5204  
 1-800-888-2738, extension 8391

## CREDIT INSURANCE COMPANY

- American Guaranty Insurance Company
- American Republic Insurance Company
- Life of the South Insurance Company
- Southern Financial Life Insurance Company
- Triangle Life Insurance Company
- \_\_\_\_\_

**This form must be completed in full and FAXED to 904-359-2041**

CREDITOR'S	1. Claimant's Name			Loan Number		Certificate Number		
	2. Issue Date	Amount	First Payment Due	# of Payments Made	Waiting Period		<input type="checkbox"/> Elimination	
							<input type="checkbox"/> Retroactive _____ Days	
	3. How Payable? _____ months @ \$ _____		Is there any other insurance on this or other notes with your company? Is this a renewal loan? If yes, how many loans? _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
							<input type="checkbox"/> No	
	4. Name of Dealer		Address		City	State	Zip	Phone Number
	5. Creditor Payee		Address		City	State	Zip	Phone Number
6. Mail check to the Attn. of:				Is a copy of the insurance certificate attached?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
				If No, explain:				
7. 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 FRAUD WARNING STATEMENTS ATTACHED

CLAIMANT'S	Full Name of Claimant			Telephone Number	Social Security Number		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	<input type="checkbox"/> Hour	
						\$ _____	<input type="checkbox"/> Week	
							<input type="checkbox"/> Month	
							<input type="checkbox"/> Year	
	When did you become totally disabled (unable to do any work)? _____						Have you ever had this or a similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	When did you or do you expect to return to light work? _____						When?	
	When did you or do you expect to return to full time work? _____							
<b>Accident Claims Only</b>	Date & Time Injury Occurred? <input type="checkbox"/> AM <input type="checkbox"/> PM	Were you injured at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Briefly describe how, when, where and why this injury incurred in the space below:					
Were you hospitalized confined? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and Address of the Hospital			Date Admitted:			
Have you performed any work other than your usual occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No				Are you receiving or entitled to receive any other disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "yes," give nature of work and dates worked.				Source and 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.								

**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 attached Fraud Warning Statement.


\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Claimant

**ALL QUESTIONS MUST BE FULLY ANSWERED OR DELAY WILL RESULT**

## 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																					
<b>1. HISTORY</b> (a) When did symptoms first appear or accident occur? MO. _____ DAY _____, _____ (b) Date patient ceased work because of disability? MO. _____ DAY _____, _____ (c) Has patient ever had same or similar condition? YES <input type="checkbox"/> NO <input type="checkbox"/> If Yes, state when and describe:  (d) Name and address of referring physician (e) What other physicians have treated the patient?																						
<b>2. PRESENT CONDITION</b> (a) Subjective Symptoms (b) Objective Findings Include results of current X-rays, EKG's or any other special tests. (c) Is Patient Ambulatory? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> House Confined? <input type="checkbox"/> Hospital Confined? <input type="checkbox"/>																						
<b>3. DIAGNOSIS (ICD Code Required)</b>																						
<b>4. TREATMENT</b> (a) Date of first visit for this condition MO. _____ DAY _____, _____ (b) Date of last visit MO. _____ DAY _____, _____ (c) Frequency of visits WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER _____ (d) Next appointment date _____ DAY _____																						
<b>5. PROGRESS</b> RECOVERED <input type="checkbox"/> IMPROVED <input type="checkbox"/> UNIMPROVED <input type="checkbox"/> RETROGRESSED <input type="checkbox"/>																						
<b>6. EXTENT OF DISABILITY</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"></td> <td style="width: 25%; border: none; text-align: center;">FOR ANY OCCUPATION</td> <td style="width: 25%; border: none; text-align: center;">FOR REGULAR OCCUPATION</td> </tr> <tr> <td style="border: none;">(a) Is Patient now totally disabled?</td> <td style="border: none; text-align: center;">YES <input type="checkbox"/> NO <input type="checkbox"/></td> <td style="border: none; text-align: center;">YES <input type="checkbox"/> NO <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">(b) If no, when was patient able to go to work?</td> <td style="border: none; text-align: center;">MO. _____ DAY _____, _____</td> <td style="border: none; text-align: center;">MO. _____ DAY _____, _____</td> </tr> <tr> <td style="border: none;">(c) If yes, when do you think Patient will be able to resume work? If release date note given, approximate date _____</td> <td style="border: none; text-align: center;">MO. _____ DAY _____, _____</td> <td style="border: none; text-align: center;">MO. _____ DAY _____, _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;">Release Date <input type="checkbox"/> less than 3 months</td> <td style="border: none; text-align: center;"><input type="checkbox"/> 3 to 6 months <input type="checkbox"/> Never</td> </tr> <tr> <td style="border: none;">(d) If yes, is Patient suitable candidate for a rehabilitation program?</td> <td colspan="2" style="border: none; text-align: center;">YES <input type="checkbox"/> NO <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">(e) Are there any complications which would prolong disability? Describe Complications:</td> <td colspan="2" style="border: none; text-align: center;">YES <input type="checkbox"/> NO <input type="checkbox"/></td> </tr> </table>			FOR ANY OCCUPATION	FOR REGULAR OCCUPATION	(a) Is Patient now totally disabled?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	(b) If no, when was patient able to go to work?	MO. _____ DAY _____, _____	MO. _____ DAY _____, _____	(c) If yes, when do you think Patient will be able to resume work? If release date note given, approximate date _____	MO. _____ DAY _____, _____	MO. _____ DAY _____, _____		Release Date <input type="checkbox"/> less than 3 months	<input type="checkbox"/> 3 to 6 months <input type="checkbox"/> Never	(d) If yes, is Patient suitable candidate for a rehabilitation program?	YES <input type="checkbox"/> NO <input type="checkbox"/>		(e) Are there any complications which would prolong disability? Describe Complications:	YES <input type="checkbox"/> NO <input type="checkbox"/>	
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<b>7. CARDIAC (if appropriate)</b> (a) Functional Capacity (American Heart Association) CLASS 1 (No Limitation) <input type="checkbox"/> CLASS 2 (Slight Limitation) <input type="checkbox"/> (b) Blood Pressure CLASS 3 (Marked Limitation) <input type="checkbox"/> CLASS 4 (Complete Limitation) <input type="checkbox"/>																						
<b>8. Is condition due to injury or sickness arising out of patient's employment?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <table style="width: 100%; border: none; margin-left: 150px;"> <tr> <td style="width: 33%; border: none;">Pregnancy? YES <input type="checkbox"/> NO <input type="checkbox"/></td> <td style="width: 67%; border: none;">If yes, approximate date pregnancy commenced. Date _____ E.D.C. _____</td> </tr> </table>		Pregnancy? YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, approximate date pregnancy commenced. Date _____ E.D.C. _____																			
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	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date _____ Is this claim one that may be covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	3. Is he still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was he laid off? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was leave of absence granted? <input type="checkbox"/> Yes <input type="checkbox"/> No		When did leave start, layoff start, or employment terminate? Date _____	
	4. When did employee become totally disabled to work. _____ When did employee return to light work. _____ When did employee return to full time. _____			If not resumed to work, do you expect employee to return? <input type="checkbox"/> YES <input type="checkbox"/> 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		

### MUST BE COMPLETED BY CLAIMS DEPARTMENT

Date	Action Code	Reason Code	Payment Date				Amount	Type	Payment Approved	
			From Date	Thru Date	No. Days				Exam.	Auth.

**(ALL CLAIMS SHOULD BE FILED THROUGH THE CREDITOR)**

**Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing any false, incomplete, misleading, or deceptive statement is guilty of an insurance fraud.**

## 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.