

**CREDIT DISABILITY CLAIM FOR FINANCE**  
**PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM**

- 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
  - \_\_\_\_\_

**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**

CREDITOR'S	1. Claimant's Name		Loan Number	Certificate Number		
	2. Issue Date	Amount	First Payment Due	Waiting Period	# of Payments Made	
			<input type="checkbox"/> Elimination _____ Days <input type="checkbox"/> Retroactive _____ Days			
	3. How Payable		4. Is there other insurance on this or other notes with your company? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	_____ Mos @ \$ _____		Is this a renewal loan? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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"/> Month	
					\$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Year	
	Date you became totally disabled (unable to do any work)?		Date you expect to return to work:		Have you ever had this or a similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			light work _____ full time work _____		If yes, give date _____	
	<b>Accident Claims Only</b>	Date and 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.
	Were you hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and Address of the Hospital _____			
	Date Admitted: _____		City _____		State _____	Zip _____
	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 _____		
				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 attached Fraud Warning Statement.

Date: \_\_\_\_\_ Signature of Claimant: \_\_\_\_\_

## 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) 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 <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> Is Patient      Ambulatory? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> House Confined? <input type="checkbox"/> Hospital Confined? <input type="checkbox"/> Subjective Symptoms _____ Objective Findings _____ Include results of current X-rays, EKG's or any other special tests.					
<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 _____					
<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> 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, provide dates Patient was totally disabled from work? FROM _____/_____/_____ TO _____/_____/_____ If release date not given, approximate date: _____      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? YES <input type="checkbox"/> NO <input type="checkbox"/> Describe Complications: _____					
<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> Pregnancy?      If yes, approximate date pregnancy commenced. YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
	3. Are they still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were they 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. Date employee became totally disabled to work. _____				If not returned to work, do you expect employee to return? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Date employee returned to light work _____				
	Date employee returned to full time work _____				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.