American Underwriters Life Insurance Company Phoenix, Arizona	Great Fidelity Life Insurance Company Indianapolis, Indiana	Century Life Assurance Company Oklahoma City, Oklahoma	United Fidelity Life Insurance Company Dallas, Texas

Administrators: Inter-Americas Insurance Corporation, Inc.
P.O. Box 9510, Wichita, Kansas 67277
Phone: (316) 794-2200 Fax: (316) 794-8470 Email: iai@iai-online.com

CLAIMANT'S STATEMENT FOR DISABILITY CLAIM

Statement of the Creditor

Name of Debtor__________________________ Certificate or Policy #______________

Original Loan Date______________________ Original Amount of Insurance $______________

Original Monthly Payment______________________ Term of Loan in Months______________

For Monthly Outstanding Balance and CAP Accounts – Send Loan History for the six months preceding the date of claim.

Current Mo. Pmt. $__________ Loan Balance on date of disability $__________ Current Int. Rate____%

Creditor__________________________ Member's account #______________

Address__________________________ City______________ State________ Zip__________

Date Signed__________ Signature__________________ Title______________ Phone ( )__________

Statement of the Insured (please print)

> **WARNING:** For your protection, some states, including California, require the following to appear on this form: **Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime and subject to a fine and/or imprisonment.**

All questions must be completed in full before your claim will be considered for payment. Any missing information or incomplete answers will delay the evaluation of your claim.

1. Name in full __________________________ Date of birth ____________ SS # ____________
2. Describe the illness or injury (give details). __________________________
   If an accident, how, when, and where did it happen?__________________________
3. When and where were you first treated by a physician? ___/___/___ at ______________
4. Physician's name, address and phone # __________________________
   ____
5. Continuously confined in the hospital from ______________ to ______________
6. Hospital name, address and medical # __________________________
7. Have you ever had the same or similar illness before? ☐Yes ☐No If yes, date ______________
8. List all doctors/hospitals seen in the last 3 years. Please list your family physician first. If additional space is needed, please attach a separate page.

Doctor's Name	Address (city, state, zip)	Phone #	Condition Treated	Dates Treated

9. When did you cease work entirely? Date ____/____/____ Have you returned to work? ☐Yes ☐No
   If yes, the date you returned to work.__________________________
10. What is your occupation? ______________________ Duties: ______________________
11. Supervisor's name ______________________ Employer's name ______________________
12. Employer's full address __________________________

The undersigned hereby makes claim for insurance proceeds. I hereby certify that the foregoing answers are complete and true. It is agreed that the furnishing of this claim form or its acceptance of delivery by the company as proof does not constitute an admission of any liability, nor a waiver of any of the conditions of the insurance contract.

THE INSURED MUST SIGN BELOW AND ALSO SIGN THE AUTHORIZATIONS ON PAGE 2

Signature__________________________ Phone # ( )______________ Date______________

Home Address (no P.O. Box)______________________ City______________ State______ Zip______

Mailing Address (if different)______________________ City______________ State______ Zip______

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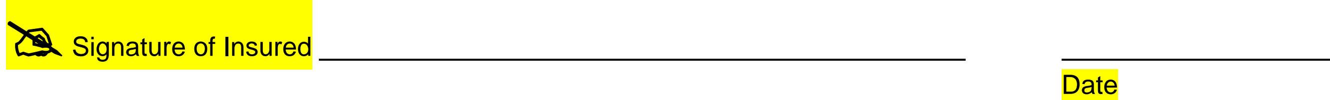
AUTHORIZATION TO RELEASE EMPLOYMENT and FINANCIAL INFORMATION

I hereby authorize any present or past employer to release any and all information acquired in the course of my employment.

I also hereby authorize the creditor to release any and all information concerning the insured loan.



Signature of Insured ____ ____________________
Date

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Insured: ____ Claim Number__________________________

I authorize any insurance company, health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to the above name person ("My Health Care Provider") to disclose the entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the insurance company named above, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict my protected health information do not apply to this authorization and I instruct any insurance company, physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so the insurance company may evaluate my claim for disability benefits.

This authorization shall remain in force for 24 months following the date of my signature below or the entire term of my disability. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the insurance company at the administrative office address above. I understand that a revocation is not effective to the extent that any of My Health Care Providers has already relied on this authorization to disclose information about me. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the insurance company except: 1) as authorized by me; 2) as required by law; or 3) to other persons or businesses with whom the insurance company has a business relationship. Such a relationship must require the receipt of my medical information in order to perform their business with the company. I also authorize this insurance company to release my information to other insurance companies or businesses (only as necessary or required to collect reimbursement for benefits paid on my behalf.

I understand that The Health Care Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance company may not be able to process my claim for benefits. I understand that any authorized representative or I will receive a copy of this authorization upon request.

____ ______________________________
Signature of Insured (or representative) Date

____
Description of representative's authority or relationship

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THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE INS. CO.

Statement of the Physician (please print)

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Any missing information or incomplete answers will delay the evaluation of the patient's claim for benefits.

1. DIAGNOSIS Patient's Name ____________________
   a) Please list all disabling conditions: ____________________
   b) Does this disability result from an accident? ☐Yes ☐No If yes, date ____________________
   c) Please list any past medical history related to current condition(s) ____________________
   d) Please list any past medical history unrelated to current condition(s) ____________________
   e) Current medications ____________________
   f) If disability is due to pregnancy, please list any complications and estimated or actual delivery dates ____________________
   g) When did symptoms first appear? ____________ Date patient first consulted you ____________
   h) Was this a referral from another physician? ☐Yes ☐No If yes, name and address of referring physician ____________________
   i) Was patient referred to another physician ☐Yes ☐No If yes, name and address of referring physician ____________________
2. DATES OF TREATMENT: (List all treatments/visits) ____________________
3. NATURE OF TREATMENT: (Including type and date of surgery and medications prescribed, if any) ____________________

   Has patient been hospital confined? ☐Yes ☐No from ____________ to ____________
   If yes, give name and address of hospital ____________________
4. PROGNOSIS

	Patient's Job	Any other work?
a) Is patient totally disabled?	☐Yes ☐No	☐Yes ☐No
b) If not now totally disabled, when was patient able to resume work?	Full-time ___/___/___ Part-time ___/___/___	Full-time ___/___/___ Part-time ___/___/___

   c) Restrictions: Lifting ____ lbs. Standing ____ hrs. Sitting ____ hrs. Walking ____ % per day
   Repetitive Bending ☐Yes ☐No Squatting ☐Yes ☐No Stooping ☐Yes ☐No
   d) What specific medical restrictions prevent the patient from returning to his/her previous occupation? ____________________
   e) What level of work is the patient capable of performing?
   ☐Heavy ☐Medium ☐Light ☐Sedentary ☐None
   f) TOTAL DISABILITY DATE: **(must be completed)** FROM ____________ TO ____________
   g) Expected duration of disability from patient's job? ____________ Any other work? ____________

Date ____________ ____________________
Signature Printed Name — Degree (MD, DO, etc.)

____________________ ( )
Street Address or Box No. City State Zip Code Telephone #

Employer's Statement

Name of Company ____________________

1. Original date of employment ____________________ Number of hours normally worked per week ____________
2. Was disabled: beginning ___/___/___ ☐am ☐pm Returned to work ___/___/___ ☐am ☐pm
3. Job Requirements Lifting ____ lbs. Standing ____ hrs. Sitting ____ hrs. Walking ____ % per day
   Repetitive Bending ☐Yes ☐No Squatting ☐Yes ☐No Stooping ☐Yes ☐No
4. What level of work is the employee required to perform? ☐Heavy ☐Medium ☐Light ☐Sedentary
5. What is the employee's job description? ____________________
   Is employee still employed by your firm? ☐Yes ☐No If no, termination date ____________________
6. Is there light duty work available for this employee? ☐Yes ☐No If yes, number of hours per week ____________

____________________ ( )
Date Signature Printed Name — Title Telephone #

____
Street Address or Box No. City State Zip Code

Self-Employer's Statement

I UNDERSTAND THE INFORMATION AS FOLLOWS IS SUBJECT TO PENALTY OF PERJURY IF FOUND TO BE UNTRUE. I hereby certify that I became ill or sustained injury on ____________ and that I have not been able to perform the duties of my occupation since ____________. I further certify that, I am, as of ____________ NOT receiving any wages or profit from any type of gainful self-employment. I understand that I may be required to furnish proof to support my claim. Signature ____________________ Date ____________