Instructions

Financial American Life Insurance Company

P.O. Box 41255 • Jacksonville, FL 32203

Phone: 1-844-882-1948 • Fax: 904-421-5920

YOU, YOUR TREATING PHYSICIAN AND YOUR EMPLOYER MUST COMPLETE A PORTION OF THIS CLAIM PACKET.

IF YOU HAVE MORE THAN ONE POLICY WITH OUR COMPANY, PLEASE SUBMIT ONE SET OF CLAIM FORMS INDICATING THE DIFFERENT LOAN ACCOUNT NUMBERS.

FAILURE TO COMPLETE THE REQUIRED SECTIONS AND PROVIDE THE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.

PLEASE SUBMIT ONLY ORIGINAL CLAIM FORMS TO THE ADDRESS LISTED ABOVE.

DO NOT SUBMIT THIS FORM PRIOR TO YOUR DATE OF DISABILITY OR WAITING PERIOD.

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

If the required sections are not complete or if the attachments are not included, the processing of the claim will be delayed. (Check box after each item is completed)

- ☐ 1. You, the Claimant, must complete, sign and date the Notice Of Disability Claim form. If you are receiving Social Security Disability, provide a copy of your award letter.
- ☐ 2. You, the Claimant, must complete, sign and date the Authorization To Obtain And Disclose Information.
- ☐ 3. Have your treating physician complete, sign and date the Attending Physician's Statement.
- ☐ 4. Have your employer complete, sign and date the Statement of Employer. If you are self-employed, please complete the form yourself and provide us with a copy of your most recent business tax forms.
- ☐ 5. Submit a Copy of your Retail Installment Contract or Finance Documents.

PRIVACY POLICY

Financial American Life Insurance Company Respects Your Privacy

Protecting the personal information of the individuals we serve is a priority for Financial American Life Insurance Company. We collect, retain and use personal information about individuals only for the purpose of serving their insurance needs and providing service to them.

This notice describes how we handle personal information of the individuals we serve. It is only for your information; no action on your part is needed.

What kind of information is collected and disclosed?

The type of information we may collect about you includes:

- Information you provide on applications or other forms, or in your verbal responses to our questions. This may include identifying information such as names, addresses, and telephone numbers. It also may include answers to health related questions we may ask you.
- Information about your transactions with us including policies purchased and premium payment history.
- Information we receive about you from other sources, such as your employer, doctors, hospitals, pharmacies, health insurance carriers, and other third parties.

You may have the right to access and correct personal information collected. Upon your request, we will provide you with more detailed information regarding the collection, use and disclosure of personal information, and your rights to access and correct the information. If you want to request more detailed information, contact us.

- We do not sell customer lists or any personal information regarding our customers.
- We do not disclose nonpublic personal information about customers or former customers to third parties, except as required to provide needed services to you and permitted by law.

How do we safeguard your privacy?

- We maintain physical, electronic and procedural safeguards to protect your personal information.
- We restrict access to nonpublic personal data to those employees who need to know that information in order to provide products or services to you.
- We communicate to employees, in writing, the importance of protecting confidential information. We may amend our privacy policies at any time.

If you have questions regarding this notice, please contact us at the address or phone number below.

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Authorization to Obtain and Disclose Information

X_____

Name of Claimant | Date of Birth

I authorize any employer, health care provider of any medical professional, hospital, pharmacy, or other medical care institution, the Veteran's Administration, the Medical Information Bureau, Inc., consumer reporting agency, government agency, insurance or reinsuring company, insurer, law enforcement agency, Social Security Administration, or other organization, or person having any records or information concerning this claim to provide such record or information to Financial American Life Insurance Company or any agent, attorney, consumer reporting agency, or independent administrator, acting on its behalf. With this authorization, Financial American Life Insurance Company may obtain and use health and medical information, including but not limited to information about use of drugs and/or alcohol, nicotine use, mental illness, physical diseases and illness. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I authorize Financial American Life Insurance Company personnel who obtain or who otherwise have authorized access to the information to release and disclose any such information to its reinsurers, the insured's insurance agent or agents servicing the Policy or Policies and persons or organizations, including Financial American Life Insurance Company affiliated companies, providing to Financial American Life Insurance Company services related to claims administration including legal and investigative services. It may be redisclosed to persons or entities, that are not subject to privacy regulations, which means the Protected Health Information may no longer be protected.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the insurance company and may no longer be protected by federal law.

I understand that such information will be used by Financial American Life Insurance Company for the purpose of evaluating this claim for insurance benefits and that I or any authorized representative will receive a copy of this Authorization upon request. This authorization shall be valid from the date signed for the duration of the claim for benefits. I also understand that I may revoke this authorization at any time by requesting such of Financial American Life Insurance Company in writing. I have had full opportunity to read and consider the contents of this authorization. I certify that the statements contained herein are true and correct to the best of my knowledge and belief. Signature is required for benefit consideration.

X_____

Signature (Claimant) (If Deceased, Surviving Spouse or Executor must sign) | Date

WARNING - 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 or confinement in prison.*

COLORADO ONLY – 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 mat 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement.

DC ONLY- 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 ONLY – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY ONLY – Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance 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.

NEW MEXICO ONLY – Any person who knowingly presents a false or fraudulent claim for payments 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.

OKLAHOMA ONLY – 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 false, incomplete or misleading information is guilty of a felony.

OHIO ONLY – 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 a false or deceptive statement is guilty of insurance fraud.

TEXAS ONLY – Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinements in state prison.

VIRGINIA ONLY – * This notice is not applicable to life and health insurance.

Notice of Disability Claim

Financial American Life Insurance Company

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Phone: 1-844-882-1948 • Fax: 904-421-5920

Do not submit this form alone. This form must be accompanied by the Attending Physician's Statement and the Statement of Employer when submitting to the Company.

For Claimant to Complete (Please print clearly and fill **ALL** blank spaces. Illegible words or blank spaces will delay the processing of your claim.)

A. Name_____ Soc. Sec. No. ☐☐☐ – ☐☐ – ☐☐☐☐

Street Address_____ City_____ State_____ Zip_____

Telephone Number ( ) _____ Date of Birth ☐☐ – ☐☐ – ☐☐☐☐ E-mail Address _____

B. Name and Address of Lending Institution (where you send your payment).

_____

_____

Lending Institution Telephone Number ( )_____

C. Date of Loan ☐☐ – ☐☐ – ☐☐☐☐

Due Date_____

Loan Account No._____

Certificate No._____

Was the loan refinanced?

☐ Yes ☐ No

If Yes, When_____

_____

D. Employer on Effective Date of Loan

Name_____

Address_____

Telephone Number ( )_____

E. Current Employer (If Different from Employer in Section D)

Name_____

Address_____

Telephone Number ( )_____

F. Are you self-employed? ☐ Yes ☐ No If YES, please provide a copy of your most recent business tax form.

Are you retired? ☐ Yes ☐ No If Yes, provide date ☐☐ – ☐☐ – ☐☐☐☐ Reason_____

G. Describe your disability. (If injury was due to an auto accident, provide a copy of the motor vehicle accident report.)

_____

_____

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If Yes, explain_____

Is your disability caused by an accident? ☐ Yes ☐ No If Yes, explain_____

Date symptoms first appeared ☐☐ – ☐☐ – ☐☐☐☐ Date you were first treated by a physician ☐☐ – ☐☐ – ☐☐☐☐ Date you became totally disabled ☐☐ – ☐☐ – ☐☐☐☐

H. Provide complete **names and addresses** of all treating physicians, including family physician, hospitals and pharmacies **within the past five (5) years**

Name Street City State Zip Phone #

Physician:_____

Physician:_____

Physician:_____

Hospital:_____

Hospital:_____

Pharmacy:_____

Pharmacy:_____

***Attach a separate sheet if more space is needed.**

Reason/Diagnosis:_____

_____

_____

I. Are you now receiving or have you ever received a disability pension or compensation? ☐ Yes ☐ No If Yes, provide date ☐☐ – ☐☐ – ☐☐☐☐

Are you receiving Railroad Compensation Benefits? ☐ Yes ☐ No

Are you receiving Social Security Disability benefits? ☐ Yes ☐ No If Yes, provide award date ☐☐ – ☐☐ – ☐☐☐☐ **ATTACH A COPY OF YOUR AWARD LETTER.**

Have you filed for Unemployment Compensation? ☐ Yes ☐ No If receiving, provide date benefits began ☐☐ – ☐☐ – ☐☐☐☐

X

Signature of Claimant Date

NODC.CL (12/10)Rev.05.17

Attending Physician's Statement

Financial American Life Insurance Company

P.O. Box 41255 • Jacksonville, FL 32203

***Phone:** 1-844-882-1948 • **Fax:** 904-421-5920*

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IF DIAGNOSIS IS RELATED TO MENTAL OR PSYCHIATRIC ILLNESS, PLEASE FILL OUT THE BACK PORTION OF THIS FORM.

Patient Name (Please Print)	Height	Weight	Date of Birth	Social Security Number
			☐☐ – ☐☐ – ☐☐☐☐	☐☐☐ – ☐☐ – ☐☐☐☐

History

A. When did symptoms first appear or accident happen? _____/_____/_____

B. Date of 1st consultation for this condition _____/_____/_____

C. Date you advised your patient to stop working _____/_____/_____

D. Has patient ever had same or similar condition? ☐ Yes ☐ No If Yes, when? _____/_____/_____

E. Is condition due to or exacerbated by an injury? ☐ Yes ☐ No ☐ Unknown

F. Name and address of referring physician (If any)

Diagnosis

A. Diagnosis (Including any Complications)

Include ICD 9 code

B. Is Condition Due to Pregnancy? ☐ Yes ☐ No

Estimated Date of Delivery: _____/_____/_____

Treatment

A. Date of last visit _____/_____/_____

B. Date of next visit _____/_____/_____

C. Frequency of visits

D. Has patient had surgery? ☐ Yes ☐ No If Yes, when? _____/_____/_____ Type of surgery performed:

E. Describe current and future treatment plan (including surgery and medications prescribed, if any.) Provide all applicable dates.

Progress

A. Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

B. Is patient ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

C. When will patient:
Return to Patient's Occupation ☐ 1–3 mos. ☐ 3–6 mos. ☐ 6–12 mos. ☐ more than 12 ☐ Never
Return to Any Occupation ☐ 1–3 mos. ☐ 3–6 mos. ☐ 6–12 mos. ☐ more than 12 ☐ Never

D. Has patient been admitted to a hospital? ☐ Yes ☐ No If Yes, confined from _____/_____/_____to_____/_____/_____

E. Name and address of hospital

Classification

A. Physical Impairment (*As defined in federal dictionary of occupational titles)

☐ Class 1 - No limitation of functional capacity; capable of heavy work.* No restrictions.

☐ Class 2 - Medium manual activity.*

☐ Class 3 - Slight limitation of functional capacity; capable of light work.*

☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity.

☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity.

B. Blood pressure last visit

_____
Systolic/Diastolic

C. In your expert opinion, how would you qualify this patient?
☐ **Permanently** Disabled
☐ **Temporarily** Disabled ☐ Non-Disabled

Prognosis

A. Does patient currently have Limitations/restrictions from:
Patient's Occupation: ☐ Yes ☐ No
Any Occupation: ☐ Yes ☐ No

B. Describe specific limitations and/or restrictions

C. If the limitations and/or restrictions can be accommodated, would you release patient to return to work? ☐ Yes ☐ No
If Yes: ☐ Part time ☐ Full time If No, explain:

D. Date employment could begin _____/_____/_____

Name of Attending Physician - PLEASE PRINT | Degree & Specialty

Street Address | City | State | Zip

X

Signature of Attending Physician (The above statements are true and complete to the best of my knowledge.) Date

Are you, the physician, related to this patient? ☐ Yes ☐ No
If Yes, what is the relationship?

Telephone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐

Fax Number ☐☐☐ – ☐☐☐ – ☐☐☐☐

SECTION C - STATEMENT OF ATTENDING PHYSICIAN (Please Print)

If this claim form is not fully completed, processing of benefits will be delayed until all required information has been received. Write N/A in non-applicable sections.

Patient Name (Please Print)	Date of Birth	Social Security Number
	☐☐ – ☐☐ – ☐☐☐☐	☐☐☐ – ☐☐ – ☐☐☐☐

A. Have you advised your patient to stop working? ☐Yes ☐ No If Yes, what date ____/____/____

B. Has patient ever had same or similar condition? ☐ Yes ☐ No

If Yes, please provide your rationale for recommending disability leave.

_____ If Yes, when? ____/_____/_____

C. Diagnostic Impressions: Axis I: _____ Axis IV:_____

Axis II: _____ Axis V: Global Assessment of Functioning; Current_____

Axis III: _____ Prior to Work Leave: _____

D. What was the patient's emotional state during the most recent exam? (Describe affect type, range, intensity and congruence with content discussed)

Panic Attacks ☐ Yes ☐ No, please specify below:

• Frequency of panic attacks:_____ • Duration of panic attacks:_____

E. Behaviors observed during exam:_____

Psychomotor activity and ability to apply effort: ☐ Unremarkable ☐ Impaired; Describe:_____

Presented with appropriate dress and hygiene in session? ☐ Yes ☐ No; Describe:_____

Impulse Control (e.g. substance abuse, manic behavior, aggressive behavior):_____

Speech: ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over Productive ☐ Under Productive

F. Risk to self/others:

Suicidal Ideations ☐ Yes ☐ No Homicidal Ideations ☐ Yes ☐ No Plan reported; If Yes, please describe_____

Able to report reasons for not harming self/others? ☐ Yes ☐ No, please explain_____

G. Date initiated care:_____/_____/_____

Inpatient Care: Date(s) of Hospitalization_____/_____/_____

Last office visit_____/_____/_____ Next office visit_____/_____/_____

Intensive Outpatient (IOP)____/___/___ to ____/____/____ Days per week _____ Hours per day_____

Outpatient Psychotherapy: Frequency:_____ Date of next scheduled visit:_____/_____/_____

Medication Management: Frequency:_____ Date of next scheduled visit:_____/_____/_____

Current Medications/changes in medication:_____

_____

I. Medication side effects: ☐ Yes ☐ No; Describe side effects _____

H. Currently, patient is:

☐ Released to work full duty as of _____/_____/_____

☐ Released to return with restrictions as of _____/_____/_____

Please list restrictions:

☐ Unable to work at this time. Give exact dates of disability:

_____/_____/_____ to _____/_____/_____

Name of Attending Physician (PLEASE PRINT)	Degree & Specialty	Telephone
Street Address	City / State	Fax Number

X _____

Signature of Attending Physician (The above statements are true and complete to the best of my knowledge.) Date

Statement of Employer

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IF YOU ARE SELF-EMPLOYED PLEASE COMPLETE THIS FORM YOURSELF AND PROVIDE A COPY OF YOUR BUSINESS INCOME TAX FORMS.

EMPLOYER MUST COMPLETE THIS FORM (PLEASE PRINT) **Check this box if self-employed ☐**

A. Employer's Name and Address

B. Employee's Date of Birth ☐☐ – ☐☐ – ☐☐☐☐ Employee's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

C. Employee's Name and Address

D. Employment Classification
☐ Full Time ☐ Other: Explain_____
☐ Part Time

E. Date of Hire _____/_____/_____ Occupation on date last worked

F. Has employee been laid off or on medical leave in the last 2 years?
☐ Yes ☐ No If Yes, provided date_____

G. Brief description of job activities on date last worked

(We may require a copy of employee's job description and/or attendance history.)

H. Employee's work schedule
Check off regular workdays
☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT

_____ Days per week
_____ Hours per day

I. Date last worked _____/_____/_____

J. Current employment status:
☐ Medical Leave ☐ Other Leave of Absence
☐ Terminated ☐ Retired
☐ Other: Explain_____

K. Has employee returned to work? ☐ Yes ☐ No
If Yes, provide date _____/_____/_____
☐ Full Time ☐ Regular Position
☐ Part Time ☐ Other Position

L. Still Employed? ☐ Yes ☐ No
If No, check the appropriate box:
☐ Layoff
___ Seasonal
___ Non Seasonal
☐ Terminated
☐ Strike
☐ Retired
☐ Disability Leave
☐ Normal Shutdown
☐ Voluntary Termination
☐ Military Leave
☐ Willful/Criminal Misconduct
☐ Other: Explain_____

M. Are you able to accommodate the medical restrictions and/or limitations? (i.e., job modification, part time, etc.)
Explain _____

N. Is employee eligible for:

	Yes	No
Group Benefits	☐	☐
Workers' Compensation	☐	☐

	Yes	No
Has Workers' Compensation claim been filed?	☐	☐

If Workers' Compensation claim has been denied, please submit a copy of the denial with this claim.

Name of Group Carrier, Address and Telephone Number

Name of Workers' Compensation Carrier, Address and Telephone Number

Group Policy No.

Workers' Compensation ID No.

O. Employer's Taxpayer ID Number (EIN) or Public Employer Social Security Number. If you have neither, explain.

Telephone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐ Extension ☐☐☐☐ Fax Number ☐☐☐ – ☐☐☐ – ☐☐☐☐

X

Name/Title of Authorized Representative (Please Print) Signature of Authorized Representative Date

(The above statements are true and complete to the best of my knowledge.)