Claim For Continuing Credit Disability Benefits

Financial American Life Insurance Company

P.O. Box 41255 • Jacksonville, **FL** 32203

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

SECTION A - STATEMENT OF CLAIMANT (Please Print)

Claim Number	Name	Telephone Number
		☐☐☐ – ☐☐☐ – ☐☐☐☐

Street Address (Complete only if your address has changed)	City	State	Zip

Are you working? ☐ Yes ☐ No If Yes, date work began ______/______/______ If No, what date do you anticipate returning to work? ______/______/______

Have you retired? ☐ Yes ☐ No If Yes, provide date ______/______/______ Reason______________________________

Have you applied for, or are you now receiving, Social Security Disability Benefits? ☐ Yes ☐ No If Yes, Date of award ______/______/______

Have you applied for, or are you now receiving, any disability benefits including Workers' Compensation? ☐ Yes ☐ No

ATTACH A COPY OF YOUR AWARD LETTER (if not previously provided).

____ ______/______/______

Signature of Claimant Date

SECTION B - AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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.

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.

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)	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 or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

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

Diagnosis

A. Diagnosis (Including any Complications) Include ICD 9 code

B. Subjective symptoms

C. Objective symptoms

D. If condition is due to an injury, is it: New ☐ Yes ☐ No Recurring ☐ Yes ☐ No

E. Describe other conditions and/or factors that are contributing to patient's illness or injury

Treatment

A. Date of last visit ______/______/______

B. Date of next visit ______/______/______

C. Frequency of visits

D. 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. If unchanged or retrogressed, please explain:

D. 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

E. Has patient been admitted to a hospital? ☐ Yes ☐ No If Yes, confined from ______/______/______to______/______/______

F. Name and address of hospital

Classification

Cardiac (if Applicable)
A. Functional Capacity (American Heart Assn.) ☐ Class 1 (no limitation) ☐ Class 3 (marked limitation) ☐ Class 2 (slight limitation) ☐ Class 4 (complete limitation)

B. Therapeutic Class (Activity) ☐ A. (no restric.) ☐ C. (moderate restric.) ☐ B. (slight restric.) ☐ D. (marked restric.) ☐ E. (complete restric.)

C. Blood pressure last visit ____________________ Systolic/Diastolic

Physical Impairment (*As defined in federal dictionary of occupational titles)
☐ Class 1 - No limitation of functional capacity; capable of heavy work.* No restrictions. (0–10%)
☐ Class 2 - Medium manual activity.* (15–30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work.* (35–55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60–70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75–100%)

Remarks:

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 ______/______/______

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

Name of Attending Physician - PLEASE PRINT Degree & Specially

Street Address City State Zip

Telephone Number __ __ __ – __ __ __ – __ __ __ __

Fax Number __ __ __ – __ __ __ – __ __ __ __

X ______/______/______
Signature of Attending Physician (The above statement are true and complete to the best of my knowledge.) Date