Notice of Plus Benefit Claim Form

Financial American Life Insurance Company

P.O. Box 41255, Jacksonville, FL 32203

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

INSTRUCTIONS: YOU AND YOUR EMPLOYER MUST FULLY COMPLETE A SECTION OF THIS CLAIM FORM. PLEASE SUBMIT ONLY ORIGINAL CLAIM FORMS. PLEASE PROVIDE A COPY OF YOUR RETAIL INSTALLMENT CONTRACT OR FINANCE DOCUMENTS. PLEASE ATTACH A COPY OF ALL CHECK STUBS RECEIVED FROM THE STATE OF OHIO BUREAU OF EMPLOYMENT SERVICES. FAILURE TO COMPLETE REQUIRED SECTIONS AND PROVIDE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.

YOU ARE RESPONSIBLE TO CONTINUE MAKING THE REQUIRED PAYMENTS TO THE CREDITOR DURING THE PERIOD YOUR CLAIM IS PENDING.

ALL BENEFIT PAYMENTS ARE PAID DIRECTLY TO YOUR CREDITOR.

SECTION A **- TO BE COMPLETED BY THE CLAIMANT** (Please Print Clearly and Fill in All Blanks)

CLAIMANT SECTION

Name _____ Date of Birth ☐☐-☐☐-☐☐☐☐ Social Security Number ☐☐☐-☐☐-☐☐☐☐

Address _____ City _____ State _____ Zip _____ Telephone ( )_____

CURRENT TERM OF UNEMPLOYMENT

I hereby state that I have been unemployed from: _____/_____/_____ to _____/_____/_____
Mo/ Day/ Year Mo/ Day/ Year

Date last employed: _____/_____/_____ Have you returned to work? ☐ YES ☐ NO If Yes, give return to work date: _____/_____/_____

CREDITOR INFORMATION

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

_____

Date of Loan _____/_____/_____Loan Account Number _____

Certificate No._____ Was the loan refinanced? ☐ Yes ☐ No If Yes, When _____

****WARNING-ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS 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.**

I authorize any employer, health care provider of any medical profession, 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.

Claimant's Signature _____ Date _____/_____/_____

(CONTINUED ON BACK)

SECTION B - STATEMENT OF EMPLOYER (MOST RECENT EMPLOYER)

Employee Name_____Last Date Worked_____/_____/_____

Date of Hire_____/_____/_____ Hired for: ☐ Full Time ☐ Part Time ☐ Seasonal

Job Title_____Number of Hours Worked Per Week_____

REASON FOR UNEMPLOYMENT:

☐ Quit ☐ Retired ☐ Military Leave ☐ Disabillity Leave ☐ Strike ☐ Normal Shutdown

☐ Criminal Misconduct ☐ Layoff ___Seasonal ____Non-Seasonal ☐ Terminated ☐ Other_____

Name of Employer_____Telephone ( )_____ Fax ( )_____

Mailing Address_____City_____State_____Zip Code_____

Signature of Authorized Representative_____

Title_____Date_____/_____/_____

SECTION C
STATEMENT OF EMPLOYER (EMPLOYER ON EFFECTIVE DATE OF LOAN IF DIFFERENT FROM MOST RECENT EMPLOYER)

Employee Name_____Last Date Worked_____/_____/_____

Date of Hire_____/_____/_____ Hired For: ☐ Full Time ☐ Part Time ☐ Seasonal

Job Title_____Number of Hours Worked Per Week_____

REASON FOR UNEMPLOYMENT:

☐ Quit ☐ Retired ☐ Military Leave ☐ Disabillity Leave ☐ Strike ☐ Normal Shutdown

☐ Criminal Misconduct ☐ Layoff ___Seasonal ____Non-Seasonal ☐ Terminated ☐ Other_____

Name of Employer_____Telephone ( )_____ Fax ( )_____

Mailing Address_____City_____State_____Zip Code_____

Signature of Authorized Representative_____

Title_____Date_____/_____/_____