LIFE ASSURANCE COMPANY

☐ NEW CLAIM ☐ CONTINUING CLAIM

CREDIT DISABILITY CLAIM

WARNING: ***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 any false, incomplete, misleading, or deceptive statement is guilty of an insurance fraud.***

CREDITOR'S STATEMENT

NAME OF INSURED _____ LOAN # _____

NAME OF CREDITOR BENEFICIARY (Where payments are due) _____

_____

ADDRESS OF CREDITOR | CITY OR TOWN | STATE | ZIP CODE | TEL #

POLICY # _____ EFFECTIVE DATE _____ ORIGINAL AMT. OF INS. _____ MO. BEN. _____

POLICY WAS PURCHASED AT _____ CREDITOR STATEMENT COMPLETED BY _____

PHYSICIAN'S STATEMENT (To be completed by the treating physicians)

PATIENT'S NAME _____ DIAGNOSIS OF DISABILITY _____

DATE CONDITION FIRST PRESENTED _____ DATE PATIENT FIRST CONSULTED FOR THIS CONDITION _____

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

DATE AND TYPE OF SURGERY _____ DATES OF HOSPITAL CONFINEMENT _____

WAS PATIENT TOTALLY DISABLED FROM USUAL OCCUPATION? ☐ YES ☐ NO DISABLED FROM ANY OCCUPATION? ☐ YES ☐ NO

DATES OF TOTAL DISABILITY: FROM _____ TO _____ DATES OF PARTIAL DISABILITY: FROM _____ TO _____

DATES OF TREATMENT/OFFICE VISITS FOR THIS DISABILITY _____

_____

DATE OF NEXT SCHEDULED TREATMENT/OFFICE VISIT _____ WHAT ARE PATIENT'S RESTRICTIONS? _____

NAMES AND ADDRESSES OF PRIMARY CARE PHYSICIAN/FAMILY DOCTOR

_____ SIGNED X _____
(ATTENDING PHYSICIAN) DEA#

_____ PRINT NAME _____

_____ DATE SIGNED _____

_____
PHYSICIAN'S ADDRESS | CITY OR TOWN | STATE | ZIP CODE | TEL #

EMPLOYER'S STATEMENT (To be completed by employer)

COMPANY NAME _____ DATE OF HIRE _____

FIRST DATE ABSENT _____ FIRST DATE RETURNED _____ DO YOU HAVE LIGHT DUTY AVAILABLE? _____

DESCRIPTION OF DUTIES _____

IF SELF EMPLOYED, PLEASE INDICATE NAME AND TYPE OF BUSINESS _____

SIGNATURE OF EMPLOYER _____ DATE _____ TELEPHONE# _____

_____
ADDRESS OF EMPLOYER | CITY OR TOWN | STATE | ZIP CODE

CLAIMANT'S STATEMENT (To be completed by the insured)

Full Name | Telephone | Social Security No. | Date of Birth

Street Address | City | State | Zip Code

Name and Address of your Employer

Describe the activities required to perform your job.

DESCRIBE DISABILITY

When did you become totally disabled (unable to do any work)? _____
When did you or do you expect to return to light work? _____
When did you or do you expect to return to full time work? _____

Have you ever had this or a similar condition before?
☐ Yes ☐ No When?

IS THIS CLAIM THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO (IF YES PROVIDE COPY OF ACCIDENT OR WORKERS COMP. REPORT.)

Have you performed any work other than your usual occupation?
☐ Yes ☐ No
If "yes", give nature of work and dates worked.

Are you receiving or entitled to receive any other disability benefits? ☐ Yes ☐ No
Source and amount

Give names and addresses of all doctors seen in last 12 months.

_____

_____

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 Life Assurance Company, Inc. or agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the insured 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 my 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.

_____ _____
Date Signature of Insured

ALL QUESTIONS MUST BE FULLY ANSWERED OR DELAY WILL RESULT

CLAIM INSTRUCTION SHEET

Please find the enclosed claim form you requested. As you will see, there is a section for your creditor's statement(you may complete this yourself), your physician's statement, your employer's statement, and your statement(claimant). All portions of this claim should be completed in full in order to process the claim. If you have difficulty completing the creditor statement, you may refer to your certificate of insurance. An incomplete form may cause a delay in processing.

EXPLANATION OF CREDITOR'S STATEMENT

1. NAME OF INSURED.....PERSON WITH INSURANCE COVERAGE
2. LOAN#.....YOUR ACCOUNT NUMBER WITH YOUR CREDITOR
3. NAME OF CREDITOR BENEFICIARY.....WHO DID YOU FINANCE THE LOAN THROUGH
4. CREDITOR ADDRESS.....WHERE YOU SEND YOUR PAYMENTS
5. POLICY#.....CREDIT INSURANCE CERTIFICATE NUMBER
6. EFFECTIVE DATE.....DATE YOU MADE PURCHASE
7. ORIGINAL AMT. OF INS.....ORIGINALS $ AMOUNT OF INSURANCE COVERAGE
8. MO. BEN.....MONTHLY AMOUNT OF INSURANCE COVERAGE
9. POLICY PURCHASED AT.....WHERE INSURANCE PURCHASED
10. COMPLETED BY.....SIGNATURE OF PERSON COMPLETING SECTION

***Below are some answers to often asked questions to help you better understand the procedure when filing a disability claim. When you have completed your claim form and are ready to mail it please verify the address you are mailing. **(Life Assurance Company, P.O. Box 20667, Oklahoma City, OK 73156)** It is a good idea to keep a copy of the claim form and the instruction sheet handy for future reference. We recommend that you always mail the form directly to the insurance company yourself and not depend on any other company or person to do so for you.

1. You must be off work due to disability for a specified waiting period before you are entitled to benefits. Consult your insurance policy in order to find out the number of days your waiting period would be. **Keep in mind**, do not start the claim process until your waiting period has been met. If there are circumstances that pertain to your claim which cannot be explained on your form, attach your written statement to the claim. **MAKE SURE YOUR FORM IS FILLED OUT CLEARLY AND COMPLETELY AND KEEP IN MIND THAT ILLEGIBLE OR INCOMPLETE FORMS MAY CAUSE DELAY IN PROCESSING.**
2. We recommend that you do not mail your employer or doctor the form in order to have them complete their statements. Take them in person and wait for it to be filled out and signed if possible. If it isn't possible for you to deliver the form, send a letter with the form explaining what you need and have them mail the form back to you. **DO NOT** depend on a physician or an employer to mail it to the insurance company. **YOU** are responsible for getting the form completed throughout the duration of your disability term and getting them to the insurance company. These completed forms are needed periodically to confirm continued disability.
3. The initial review of your claim will be done as soon as possible upon receipt of the necessary information. If the form is incomplete, illegible, or additional information has to be requested, the sooner the information is provided the sooner we will be able to process your claim. Until the insurance company settles the claim, you are responsible for your loan payment. When a claim is paid, a check will be issued directly to your creditor and you will receive a copy of such payment.

IF YOU HAVE ANY QUESTIONS, DO NOT HESITATE TO CALL 1-800-522-1314.