FIRST ASSURANCE LIFE OF AMERICA

CLAIMS OFFICE: P.O. DRAWER 83480, BATON ROUGE, LA 70884-3480

ACCIDENT AND HEALTH (DISABILITY) CLAIM FORM INSTRUCTIONS

ATTACHED YOU WILL FIND AN INITIAL CLAIM FORM USED FOR FILING A DISABILITY CLAIM WITH FIRST ASSURANCE LIFE OF AMERICA. THIS CLAIM FORM MUST BE COMPLETED FULLY AND CORRECTLY BY THE CLAIMANT. IT IS IMPORTANT THAT YOUR CERTIFICATE(S) AND LOAN INFORMATION ON THE CLAIM FORM BE COMPLETED. THIS INFORMATION IS NEEDED TO IDENTIFY YOUR COVERAGE AND YOUR PROPER LIENHOLDER. ALL QUESTIONS MUST BE COMPLETED IN THEIR ENTIRETY. THE CLAIM FORM MUST ALSO BE COMPLETED FULLY BY YOUR ATTENDING PHYSICIAN AND EMPLOYER. YOU ARE RESPONSIBLE FOR THE COMPLETION OF YOUR CLAIM FORM. IF THE CLAIM FORM SUBMITTED TO OUR COMPANY IS INCOMPLETE, THE RESULT WILL BE A DELAY IN PROCESSING YOUR CLAIM FOR BENEFITS.

AFTER THE WAITING PERIOD OF YOUR POLICY HAS BEEN MET, THE ORIGINAL CLAIM FORM SHOULD BE COMPLETED AND SUBMITTED TO OUR OFFICE WITH ANY ATTACHMENTS OR CORRESPONDENCE. INCLUDE YOUR NAME AND POLICY INFORMATION ON ALL CORRESPONDENCE. FAX COPIES OF THE CLAIM FORM WILL BE ACCEPTED AS PROOF OF YOUR CLAIM, HOWEVER, THE ORIGINAL CLAIM FORM AND ANY ATTACHMENTS MUST BE MAILED TO OUR OFFICE.

DUE TO HIPAA REGULATIONS, THE ATTACHED AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS MUST BE COMPLETED. THIS MAY BE NECESSARY IN THE EVENT OUR COMPANY NEEDS TO REQUEST COPIES OF YOUR MEDICAL RECORDS. PLEASE COMPLETE THE "PATIENT INFORMATION" AT THE TOP OF THE AUTHORIZATION (PATIENT NAME, ADDRESS, SOCIAL SECURITY #, DATE OF BIRTH, TELEPHONE). PLEASE ALSO COMPLETE THE "PATIENT INFORMATION" AT THE BOTTOM OF THE AUTHORIZATION (SIGNATURE OF PATIENT & DATE). ATTACH AND RETURN THE AUTHORIZATION TO OUR OFFICE WITH YOUR COMPLETED INITIAL CLAIM FORM.

NOTE: WE RECOMMEND THAT YOU CONTINUE PAYMENT ON YOUR LOAN IF PAYMENT IS DUE PRIOR TO YOUR FILING AND THE APPROVAL OF YOUR CLAIM. ANY MONIES ON AN APPROVED CLAIM WILL BE FORWARDED TO THE LIENHOLDER TO CREDIT THE LOAN ACCOUNT. YOU WILL RECEIVE CREDIT FOR ALL AMOUNTS PAID BY FIRST ASSURANCE LIFE OF AMERICA TO YOUR LOAN. FIRST ASSURANCE LIFE OF AMERICA IS NOT RESPONSIBLE FOR ANY LATE CHARGES, DELINQUENT PAYMENTS OR EXTENSIONS ETC., ON YOUR LOAN(S). WE RECOMMEND THAT YOU ADVISE YOUR LIENHOLDER AS SOON AS POSSIBLE OF THE FILING OF YOUR CLAIM FOR DISABILITY BENEFITS. FIRST AMERICA LIFE OF AMERICA IS NOT RESPONSIBLE FOR DOCTOR'S EXPENSES OF COMPLETING ANY CLAIM FORMS. THIS IS THE RESPONSIBILITY OF THE CLAIMANT.

SHOULD YOU HAVE ANY QUESTIONS REGARDING THE COMPLETION OF YOUR CLAIM FORM, PLEASE DO NOT HESITATE TO CONTACT OUR OFFICE AT THE TELEPHONE NUMBERS PROVIDED BELOW.

TOLL FREE NUMBER (800) 272-8000 FAX (225) 769-4477

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INITIAL STATEMENT OF INSURED FOR ACCIDENT OR SICKNESS CLAIM
PLEASE PROVIDE THE FOLLOWING INFORMATION BEFORE FORWARDING CLAIM TO COMPANY.
ALL QUESTIONS MUST BE ANSWERED BEFORE CLAIM CAN BE CONSIDERED FOR PAYMENT.
PLEASE PRINT

POLICY INFORMATION (This must be completed in order to identify your policy.)				
Certificate Number(s)	Writing Dealer or Bank where policy purchased	Term (Months)	Effective Date	Monthly Benefit

LOAN INFORMATION (This information can be found in your loan payment booklet or statement.)			
Creditor Company (Loan financed by)	Account Number		Creditor Company Phone Number ( )
Payment Mailing Address	City	State	Zip

INSURED'S STATEMENT OF DISABILITY (MUST BE COMPLETED AND SIGNED BY CLAIMANT)			
Name	Date of Birth	Social Security Number	
Address (include apt. or lot #)	City	State	Zip
Your Phone Number ( )	Employer (If Self Employed or Unemployed, please state)	Employer Phone Number ( )	
Employer Address	Occupation/Duties		Length of Service

Date accident occurred or sickness began	Date that you stopped working	Date of first medical treatment
Nature of injury or illness	If accident, how did it happen?	

Name of Doctor or Hospital who first treated you?
Address Phone Number ( )

Name of Doctor treating you now	Doctor's Address	Phone Number ( )
Name of Family Physician	Family Physician's Address	Phone Number ( )

Were you hospital confined: No ☐ Yes ☐ Admitted on _____ Discharged on _____
Hospital Address

Have you been treated previously for this condition? No ☐ Yes ☐ If yes, when? _____

Doctor's Name Address City State Zip

Have you resumed any part of the duties of your occupation or any other employment? No ☐ Yes ☐

If yes, what date did you resume any part of your duties or work? ____ Mo. ____ Day ____ Year

Date you resumed full duties? ____ Mo. ____ Day ____ Year

AUTHORIZATION: I hereby authorize any Creditor Company (Lienholder of Loan), insurance company, group policyholder, government authority, or any past or present employer, to furnish First Assurance Life of America, its reinsurers, or their representatives, any information related to employment, or financial or credit information, for the purpose of evaluating my claim for insurance benefits. I understand that I have the right to receive a copy of this authorization. This authorization shall remain valid for the remaining term of coverage. A photostat of this authorization will be as valid as the original.

I hereby certify that the foregoing answers are complete and true. It is agreed that the furnishing of this form or its acceptance 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.

Date _____ Signature of Claimant_____

Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

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PHYSICIAN'S STATEMENT OF DISABILITY (MUST BE COMPLETED BY PHYSICIAN)

Any charge by the physician for completion of this statement shall be borne by the Insured without expense to First Assurance Life of America

Name of Patient	Date of Birth or Age

Diagnosis; Nature of illness or injury causing disability
(Describe complications, if any)

Is condition due to pregnancy? No ☐ Yes ☐ If yes, were there complications with pregnancy? No ☐ Yes ☐

Was Patient hospitalized? Hospital _____ City _____ State _____ Zip_____	No ☐ Yes ☐ Admitted on _____ Discharged on _____
Was surgery performed or being considered? (If yes, please describe nature of surgery below.)	No ☐ Yes ☐ Date of surgery _____
When did Patient first consult you for this condition? Subsequent dates of treatment?	Date _____ Dates _____
When did symptoms first appear or accident happen?	Date _____
Was Patient referred to you by another physician? No ☐ Yes ☐ (If yes, provide physician's name and address.)	Physician's Name _____ Address_____

To your knowledge, has patient ever been treated previously for this same or similar condition? No ☐ Yes ☐
(If yes, state when and describe)

Is Patient still under your care for this condition? If no, give date released or referred to other physician.	No ☐ Yes ☐ Date _____
Is Patient totally disabled (unable to work) because of this condition?	No ☐ Yes ☐
On what date did the patient first become totally disabled?	First date of disability _____
Is Patient still totally disabled (unable to work) because of this condition? If no, date of release or discharge.	No ☐ Yes ☐ Date _____
If still disabled, what is the estimated return to work date?	Date _____

If unknown, what restrictions prevent patient from returning to work? Also put any other comments or remarks below.
Remarks_____

NOTE: Any erasures or changes must be initialed by physician signing this form.

Date	Signature (Attending Physician)	Physician Name (Please Print)	

Physician's Address	City	State	Zip

Telephone No. ( )		Fax No. ( )	

EMPLOYER'S STATEMENT OF DISABILITY (MUST BE COMPLETED BY EMPLOYER)

Name of Employee	Usual Duties	Length of Service

Has the above Employee been off work due to an illness or injury? Yes ☐ If yes, date last worked: _____ No ☐	On what date did the employee return to work in any capacity? _____
Has the employee filed for worker's compensation? No ☐ Yes ☐	If yes, date of accident: _____

Employer (Company Name)	Authorized Signature Title		Date

Address	City	State Zip	Telephone No. ( )

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION: (Please Print) PatientName:_____

Full Address:_____ **Telephone: (___)**_____

Date of Birth:_____ **Social Security #:**_____

AUTHORITY TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize _____**(covered entity/ provider) to release to First Assurance Life of America the Protected Health Information (PHI) identified in this authorization form from the medical records of the Patient listed above.**

INFORMATION TO BE RELEASED - COVERING THE PERIODS OF HEALTH CARE

Disclose the following PHI for treatment date starting at _____ **to ending date** _____**.**

X Other: Entire Medical Record excluding Itemized Billing Statement

__ History & Physical Examinations	**__ Progress Notes**	**__ Discharge Summary**
__ Operative Report	**__ Consultation Reports**	**__ ER Report**
__ Laboratory Test Results	**__ Physician Orders**	**__ X-ray/Images Reports**

THE ABOVE INFORMATION IS DISCLOSED FOR THE PURPOSE OF :

Insurance - Evaluation of a claim for disability

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE OF EVENT:

Unless revoked, this authorization will expire on the following date or event:

EVENT/DATE: Two (2) years from the date of this Authorization

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RELEASE

I understand if my medical records contain information in reference to drug and/or alcohol abuse, Psychiatric Care, Communicable disease(s), Hepatitis or HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I consent and agree to the release (without restriction) of this information.

I UNDERSTAND THAT:

1. I may refuse to sign this Authorization and it is strictly voluntary.

2. I understand that my treatment, payment, enrollment or eligibility for benefits provided by or through a qualified healthcare provider may not be conditioned on signing this authorization. However, First Assurance Life of America may condition payment of a claim or the eligibility of benefits upon my signing this Authorization, if the disclosure of information is necessary to determine the validity of a claim or its payment.

3. I have the right to revoke this Authorization at any time. Revocation must be in writing, to the covered entity/provider authorized to release the Protected Health Information (PHI) or First Assurance Life of America. I understand that the revocation will not apply to information that has already been released to this Authorization.

4. I understand that once information is disclosed pursuant to this Authorization, the released information may no longer be protected by federal privacy regulations and may be subject to redisclosure by First Assurance Life of America.

5. I have the right to receive a copy of this Authorization after I sign it.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED. A COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

PATIENT INFORMATION: Signature of Patient: _____**Date:** _____

Signature of Patient's Representative (if necessary): _____ **Date:** _____

Personal Representative's Relationship to Patient: _____

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