



MONTHLY OUTSTANDING BALANCE INITIAL DISABILITY CLAIM FORM

Incomplete Information May Cause Delays and Inconvenience

Part 1 - STATEMENT OF LENDING INSTITUTION (ALTERED ANSWERS CANNOT BE ACCEPTED)

ACCOUNT NUMBER	NAME OF DEBTOR				Certificate No. _____
					Date Issued: ____/____/____
LOAN NUMBER	CLOSED END LOAN <input type="checkbox"/> Yes <input type="checkbox"/> No	Interest Rate	Date of Loan	Maturity Date	Term of Loan _____ Mos.
Payment: \$ _____ () Weekly () Bi-Weekly () Monthly () Semi-Monthly	OPEN END LOAN <input type="checkbox"/> Yes <input type="checkbox"/> No	Loan Due Date	Outstanding Balance:	Date of Last Advance:	Date of Last Payment:
Creditor: _____		By: _____		Date: ____/____/____	
Mailing Address: _____			Phone No. () _____		

Part 2 - STATEMENT OF THE CLAIMANT (ALTERED ANSWERS CANNOT BE ACCEPTED)

- Claimant's Name: _____ SS# _____
Sex: M _____ F _____ Date of Birth ____/____/____ Home Phone: () _____
 - Address: _____
City _____ State _____ Zip Code _____
 - Occupation _____ Job Duties _____
 - Are you self-employed? Yes No If yes, how many years _____
 - Have you ever had same or similar condition? Yes No If yes, when and give names of doctor who treated you for the condition:

 - List ALL doctors, including family physician and/or hospitals that have treated you for any sickness or accident within the last two years.
(If necessary, attach separate sheet)
- | <i>Name and address of provider</i> | <i>Treatment for</i> | <i>Date(s) treated</i> |
|-------------------------------------|----------------------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
- Are you receiving or have you received unemployment compensation while disabled? Yes No If "Yes", name and address of agency:

IMPORTANT INFORMATION:

- PLEASE SUBMIT THE ORIGINAL, UNALTERED, CLAIM FORM, FULLY COMPLETED.
- CLAIM PAYMENTS ARE MADE DIRECTLY TO THE LENDING INSTITUTION.
- PLEASE REMEMBER YOU ARE UNDER SEPARATE CONTRACT WITH YOUR LENDER. YOU REMAIN RESPONSIBLE FOR MAKING CERTAIN YOUR LOAN REMAINS CURRENT WHILE WE VERIFY BENEFIT ELIGIBILITY.
- YOUR CERTIFICATE DOES NOT COVER LATE CHARGES OR ADDITIONAL FEES.

I UNDERSTAND that if I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

SPECIAL NOTICE - 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 and confinement in prison.
FOR OHIO ONLY - Any person who, with intent to defraud or knowing that he 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.

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, including Social Security Administration and State Unemployment Office, insurance company, group policyholder, employer or benefit plan administrator to provide North American Insurance Company or an agent, attorney, consumer reporting agency, acting on its behalf any and all medical and non-medical information including but not limited to information concerning advice, diagnosis, care or treatment provided that patient or employee named below and information relating to mental illness use of drugs, use of alcohol, Acquired Immune Deficiency Syndrome (AIDS), or an AIDS related complex (ARC). I also authorize my employer, to provide North American Insurance Company with financial or employment-related information.

I also authorize the creditor or any transferee of the indebtedness to provide North American Insurance Company with copies of my credit application and any other information regarding the credit transaction, which is the basis of the insurance.

You may refuse authorization to disclose all or some health care information. You may also revoke the authorization in writing at any time subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation. However, such refusal or revocation may result in denial of claim or other adverse effects.

I understand that such information will be used by North American Insurance Company for the purpose of evaluating my claim for disability benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing North American Insurance Company to use and disclose protected health information.

By my signature below, I hereby certify that the answers given by me on this form are complete and true.

Claimant's Signature _____ Date _____

Claimant's Name _____ Date of Birth _____



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Part 3 - STATEMENT OF ATTENDING PHYSICIAN (ALTERED ANSWERS CANNOT BE ACCEPTED)

- 1. Patient's name:
2. Are you this patient's regular physician?
3. If not, name and address of referring physician:
4. Your first treatment date for this disability
5. Complete diagnosis including ICD-9
6. What other diseases are secondary to, complicated with, or a consequence of this condition?
7. Has patient ever had same or similar condition?
8. Is this condition work related?
9. Is condition due to pregnancy?
10. Was patient hospitalized?
11. Describe current course of treatment, including prognosis
12. Is patient still under your care?
13. Include dates of treatment for this condition during the last 2 years
14. Is your patient capable of performing the essential duties of their current occupation?
15. When did total disability begin?
16. Have you released your patient to return to work?
17. Remarks (Especially as they might help us understand patient's disability):

Signature Date DO NOT PRE-DATE
Physician's Name Degree Specialty/Board certification
Physician's Address STREET CITY STATE/ZIP
Physician's Phone Number () Physician's Fax Number ()

Part 4 - STATEMENT OF EMPLOYER (ALTERED ANSWERS CANNOT BE ACCEPTED)

TO BE COMPLETED BY AUTHORIZED PERSON OF EMPLOYER

- 1. Employee's name Job Title
2. Brief description of job duties Hours Worked Weekly
3. Dated hired Date last worked prior to disability Laid off? Still employed?
4. Has any other accident or sickness caused disability within the last 12 months?
5. Is this condition work related?
6. Date employee became totally disabled: Will light duty work be available?
7. Has employee returned to work?
Employer's Name and Address
Phone Number ()

Signed on behalf of employer by Title Date

To the best of my knowledge and belief all of the answers given by me are true and complete.