North American Insurance Company
2721 N. Central Ave.
Phoenix, AZ 85004

SINGLE PREMIUM INITIAL DISABILITY CLAIM FORM

Incomplete Information May Cause Delays and Inconvenience

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

ACCOUNT NUMBER	LOAN NUMBER	NAME OF DEBTOR		Certificate No. ___________________ Date Issued _____/_____/_____
Payment Amt $ _____________ Monthly ☐ Weekly ☐ Semi-Monthly ☐ Bi-Weekly ☐	Interest Rate	Loan Due Date _____/_____	Outstanding Balance $ _____________________	Date of Last Payment _____/_____/_____

Creditor: ____ By: ___________________________ Date: _____/_____/_____

Payment Mailing Address: ____ Phone No. ( ) _____________________

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

1. Claimant's Name:____ SS# ____________________________

   Sex: M ______ F ______ Date of Birth _____/______/______ Home Phone: ( ) ________________________________

2. Address: ____

   City ____ State ____________ Zip Code ________________________

3. Occupation _______________________________________ Job Duties ____

4. Are you self-employed? ☐Yes ☐No If yes, how many years? __________

5. Have you ever had same or similar condition? ☐Yes ☐No If yes, when and give names of doctor who treated you for the condition:

   ____

   ____

6. 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)**

Name and address of provider	***Treatment for***	***Date(s) treated***

7. 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** __________________

Mail Completed Form To: 2721 N. Central Ave – Phoenix, AZ 85004
Phone 800-585-5821 - Fax 602-263-6993

North American

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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? ☐Yes ☐No How long?__________
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? If yes, what and when ____________________
8. Is this condition work related? ☐Yes ☐No If yes, explain ____________________
9. Is condition due to pregnancy? ☐Yes ☐No If yes, include EDD ____________________
10. Was patient hospitalized? ☐Yes ☐No If yes, include admission/discharge dates and name and address of hospital ____________________
11. Describe current course of treatment, including prognosis____________________
12. Is patient still under your care? ☐Yes ☐No Last date you saw patient: _____/_____/_____ Next Appointment: _____/_____/_____
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? ☐Yes ☐No
15. When did total disability begin? ________/________/________
***TOTAL DISABILITY** is defined as a sickness or injury in which the insured is prevented from performing the essential duties of their current occupation*
16. Have you released your patient to return to work? ☐Yes ☐No
If "**Yes**" give date released _____/_____/_____ If "**No**" give ESTIMATED return to work date _____/_____/_____
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?** ☐Yes ☐No **Still employed?** ☐Yes ☐No
4. Has any other accident or sickness caused disability within the last 12 months? ☐Yes ☐No If yes, on what dates? __________
5. Is this condition work related? ☐Yes ☐No If "Yes", provide name, address and phone number of worker's compensation carrier: _______
6. Date employee became totally disabled:_____/_____/_____ Will light duty work be available? ☐Yes ☐No
7. Has employee returned to work? ☐Yes ☐No If "Yes", on what date _____/_____/_____

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.

Mail Completed Form To: 2721 N. Central Ave – Phoenix, AZ 85004
Phone 800-585-5821 - Fax 602-263-6993