



SINGLE PREMIUM INITIAL DISABILITY CLAIM FORM

Incomplete Information May Cause Delays and Inconvenience

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

Form with fields for ACCOUNT NUMBER, LOAN NUMBER, NAME OF DEBTOR, Certificate No., Date Issued, Payment Amt \$, 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?
5. Have you ever had same or similar 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.
7. Are you receiving or have you received unemployment compensation while disabled?

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 Oxford Life 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 Oxford Life Insurance Company with financial or employment-related information.

I also authorize the creditor or any transferee of the indebtedness to provide Oxford Life 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 Oxford Life 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 Oxford Life 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



SINGLE PREMIUM INITIAL DISABILITY CLAIM FORM
Incomplete Information May Cause Delays and Inconvenience

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.

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

- Patient's name: _____
- Are you this patient's regular physician? Yes No How long? _____
- If not, name and address of referring physician: _____
- Your first treatment date for this disability ____/____/____
- Complete diagnosis including ICD-9 _____
- What other diseases are secondary to, complicated with, or a consequence of this condition? _____
- Has patient ever had same or similar condition? If yes, what and when _____
- Is this condition work related? Yes No If yes, explain _____
- Is condition due to pregnancy? Yes No If yes, include EDD _____
- Was patient hospitalized? Yes No If yes, include admission/discharge dates and name and address of hospital _____
- Describe current course of treatment, including prognosis _____
- Is patient still under your care? Yes No Last date you saw patient: ____/____/____ Next Appointment: ____/____/____
- Include dates of treatment for this condition during the last 2 years _____
- Is your patient capable of performing the essential duties of their current occupation? Yes No
- 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
- Have you released your patient to return to work? Yes No
If "**Yes**" give date released ____/____/____ If "**No**" give ESTIMATED return to work date ____/____/____
- 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

- Employee name _____ Job Title _____
 - Brief description of job duties _____ Hours Worked Weekly _____
 - Dated hired ____/____/____ Date last worked prior to disability ____/____/____ **Laid off?** Yes No **Still employed?** Yes No
 - Has any other accident or sickness caused disability within the last 12 months? Yes No If yes, on what dates? _____
 - Is this condition work related? Yes No If "Yes", provide name, address and phone number of worker's compensation carrier: _____
 - Date employee became totally disabled: ____/____/____ Will light duty work be available? Yes No
 - 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.