AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE CLAIMS DEPARTMENT
P.O. BOX 4328, SPRINGFIELD, MO 65808-4328
PHONE NUMBER: 800-899-6502 FAX NUMBER: 409-766-2912
E-MAIL: CIDCLAIMSDEPT@AMERICANNATIONAL.COM

CREDIT DISABILITY CLAIM FORM INSTRUCTIONS

Enclosed is a claim form required in order to process disability payments on your loan. It is important that all questions be fully answered or delay will result. To avoid late fees, continue to make your monthly payments until you receive notification that your claim has been approved. We may need to obtain your medical records. After mailing your claim form to us, please allow ten (10) business days for processing. All benefits will be paid directly to your creditor.

Instructions:
If the anticipated period of disability is more than thirty (30) days, please complete the disability claim form, and submit it approximately thirty (30) days from the first day you missed work due to disability. You should complete this form on the 30th day of the disability, regardless of the type of disability coverage purchased (7, 14, or 30 day). Payments will be made based on the date you became disabled. This may not be the same as your payment due date; therefore, we recommend that you continue with your payments to the creditor until you are notified that your claim has been approved for payment of benefits.

If the period of disability is less than thirty (30) days, please complete the disability claim form, and submit it on the date you are released to return to work.

Your application should be completed by:

1. The Claimant (you) – Sections A and B
2. The Attending Physician – Section C
3. Your Employer – Section D

Checklist for additional information that should be submitted with your application for benefits:

_____ Copy of your insurance policy
_____ Copy of your retail installment contract. If your creditor is a credit union, please provide a copy of loan and disclosure document.
_____ Completed HIPAA authorization
_____ Completed Statement of Medical History
_____ Consent for Communication Authorization
_____ If work-related injury, copy of 1st Notice of Injury/Workers' Compensation Report

Please note: If this is an accident, please submit a copy of the accident report. If there is no accident report, please submit a statement as to what happened and why no report was filed.
If any of the above sections are left blank, the form will be returned causing a delay in processing your paperwork for payment. Your cooperation in this matter will help speed your claim processing. All payments will be made to the creditor. Once all four (4) sections are completed, please mail your completed application to the address below. FAXES and e-mails are accepted; however, originals may be required at any time.

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Should you continue to remain disabled for more than thirty (30) days, a continuation of disability form will be mailed directly to you indicating when the form should be completed and returned. The bottom portion of the continuation form will have information regarding our payment; this should be retained for your records.

If you have any additional questions, we may be reached at 1-800-899-6502. Our business hours are from 8:00 a.m. to 4:30 p.m., Central Standard Time.

FRAUD WARNINGS/STATEMENTS

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia - 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.

California - For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Delaware - Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Florida - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho - Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

New Hampshire - Any person who with a purpose to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - 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 CIVIL FINES AND CRIMINAL PENALTIES.

New York - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio - 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.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Oklahoma - "WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony."

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

Texas - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Tennessee, Maine, Virginia, Washington - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Policy Number

_____

(Please attach a copy.)

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APPLICATION FOR CREDIT DISABILITY BENEFITS

Section A – Insured's Statement

Name _____ Date of birth_____ Phone Number _____

Male/Female _____ E-mail Address_____

Street Address _____ City_____ State _____ ZIP_____

Mailing Address _____ City_____ State_____ ZIP_____

What is your business or occupation? _____ Name of employer or business _____

Address of employer or business _____ City _____ State _____ ZIP _____

Phone Number _____ Describe your specific duties to perform your job _____

_____

Cause of Disability (check one) ☐ Injury ☐ Sickness Describe Disability _____

When did you first notice symptoms of your illness, or on what day did the injury occur? _____

How did the injury happen? _____ Have you had this or a similar condition before? ☐ Yes ☐ No

If "yes," what condition and when? _____

What date did you first see a physician? _____ Where? _____

Physician Name _____ Address _____ Phone Number _____

Has any other physician treated you for this injury or illness? ☐ Yes ☐ No If "yes," when _____

Name of treating physicians _____

Dates confined to hospital: Month_____ Day_____ Year_____ to Month_____ Day_____Year_____

First date you were entirely away from work due to current disability _____ Date you returned to work _____

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

_____

Have you had any medical or surgical advice/treatment/consultation during the past 5 years for any other condition? ☐ Yes ☐ No

If "yes," what were you treated for? _____ When? _____

Physician Name _____ Address_____ Phone Number _____

Are you receiving or entitled to receive any other disability benefits? ☐ Yes ☐ No If "yes," source _____

I hereby assign, transfer, and set over all my interest in the above numbered contract pertaining to this loss, and direct that my benefits payable to me under this policy/certificate be paid to the lending institution as listed on the policy/certificate, whose receipt for benefits that may be due me shall be a full acquittance of all my claims under the said policy/certificate. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

You are authorized to permit American National Insurance Company and its subsidiaries to view and obtain a copy of records pertaining to any and all medical practitioners, physicians, pharmacists, pharmacy benefit managers, hospitals, clinics, nurses, records custodians, employers, financial custodians, law enforcement agencies, or insurance companies. I understand that the information I am authorizing to be released may include:

1. AIDS/HIV test results, diagnosis, treatment, and related information
2. Drug screen results and information about drug or alcohol use and treatment
3. Mental health information
4. Pharmacy prescriptions/Pharmacy Benefit Managers

I further understand that this authorization is valid for one year from the date executed below. I also understand that I may revoke this authorization at any time during the one year period by notifying the Claims Department in writing at the address shown at the top of this form. The information obtained by this authorization will be used to evaluate this claim. The information obtained by this authorization may be disclosed to reinsurance companies, if policy is reinsured, to any agency employed by the Company, and to any party, which the Company is required by law or subpoena to disclose. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company and may no longer be protected by the same rule that applied in the first instance.

Date _____ **Claimant** _____

(over) **Signature**

Section B – Creditor Information

Loan Number _____ Name of Debtor _____ Social Security Number _____

Effective Date of Loan _____ Monthly Payment Amount $_____ Name of Creditor_____

Address _____ Branch Number _____ Phone Number _____

Section C – Statement of Attending Physician

Patient's Name _____

Is condition due to pregnancy? ☐ Yes ☐ No If "yes," describe complications _____

Diagnosis of disability – Please mention any complications: _____

Please advise of history pertinent to the CAUSE of this disability: _____

When did this patient first consult you about this condition? _____

When did symptoms first appear or injury happen? _____

What diagnostic and/or surgical procedures were performed? _____

What treatments were prescribed? _____

Date patient was confined to a hospital: From _____ To _____

Name of hospital _____ Address _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "yes," when _____

Is patient still under your care for this condition? ☐ Yes ☐ No If "no," date discharged _____

For what have you previously treated patient? (state condition and dates) _____

How long have you been his/her physician? _____

Dates of treatment you have provided the patient in the past 90 days _____

In your opinion, when did the patient become unable to work due to disability? Month _____ Day _____ Year _____

In your opinion, when can or did the patient resume any work? Month _____ Day_____ Year _____

Was patient referred to you? ☐ Yes ☐ No If "yes," please identify _____
(Name) (Address) (City) (ZIP) (Phone Number)

_____ _____ _____

Physician's Full Name (Please Print) **Physician's Signature** **Date**

_____ _____

Address, City, State, ZIP **Phone Number**

Section D – Statement of Employer

Name of Company _____ Employee Name _____

Type of Employee: ☐ Full-Time ☐ Part-Time ☐ Seasonal Average hours worked per week _____ Date of hire _____

Description of duties _____ Do you have light duty available? _____

Do you classify employee's duties as light, medium, or heavy work? _____ Will job be held for employee? _____

First full day absent (due to disability) _____ First date returned _____

Did employee work any period between these dates? ☐ Yes ☐ No If "yes," list dates _____

Has employee filed a claim for this loss under worker's compensation? ☐ Yes ☐ No If "yes," list name, address, and phone number of carrier_____

_____ _____ _____

Employer's Signature **Title** **Date**

_____

Address of Employer **City** **State** **ZIP** **Phone Number** **Fax Number**

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STATEMENT OF MEDICAL HISTORY

Insured: _____ Claim Number: _____

Please provide the names, addresses, phone numbers, and dates of service for all of the physicians, hospitals, and pharmacies, which provided treatment for the Insured within the past five (5) years. Failure to do so may cause a delay in processing the claim. Please use the next page of this form for additional names.

PRIMARY CARE PHYSICIAN:

Name _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

OTHER PHYSICIANS and/or HOSPITALS:

Name _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

Dates of Service (From) _____ (To) _____

STATEMENT OF MEDICAL HISTORY - CONTINUED

PHARMACY: _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

PHARMACY: _____ Address _____
(Street)

Phone Number _____ _____
(City, State, ZIP)

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PART 1: CONSENT FOR COMMUNICATION

Pursuant to the Gramm-Leach-Bliley Act, American National must adhere to certain guidelines in handling credit insurance claims. Please read below and sign that you understand and give consent for the following:

I, _____, (Your Name) understand that I have filed a claim for benefits with American National.

( ) and hereby authorize any physician, hospital, government agency, insurance company, workers' compensation carrier, or organization to release to American National information regarding my medical history/treatment and any past or present employment status;

( ) and hereby authorize my creditor, _____ (Creditor's Name), to speak with American National regarding my loan account;

PLEASE INITIAL THE SPACES ( ) BY EACH PARAGRAPH THAT YOU HAVE READ AND UNDERSTAND EACH CONSENT.

The consent for communication shall remain valid through the life of the claim.

_____ _____
Please sign your name **Date**

PART 2: CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize American National to disclose to _____ _____ (Name of person to whom disclosure can be made), relationship _____ (spouse, parent, child, etc.), the following information, including, but not limited to:

Claim status
The receipt of my claim forms and subsequent payments on my claim
Medical information pending and/or obtained

I understand the consent for the release of confidential information will remain in effect for a maximum of twelve (12) months from the date of signature below, at which time a new consent must be completed. I also understand that I may revoke the consent for the release of confidential information, in writing, at any time except to the extent that action has already been taken in reliance upon it.

_____ _____
Please sign your name **Date**

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AUTHORIZATION

This authorization is designed to comply with the HIPAA Privacy Rule.

TO THE INSURED: During your claim and as a part of the claim proof requirements of your policy, American National Insurance Company (the Company) will need information to determine your eligibility for benefits. All information we obtain with this Authorization will be kept confidential. Please immediately complete, sign, date, and return this Authorization to help us promptly consider your claim. Any alteration to or limitation of this Authorization will prejudice the Company's right to independently evaluate your claim and may prevent benefits from being provided.

I AUTHORIZE THESE PERSONS OR ENTITIES HAVING ANY KNOWLEDGE OF MY HEALTH OR ME:
Physician, therapist, healer, or medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, or other medically related facility or association * other health care provider * insurance company or insurance support organization * employer, MIB, LLC, business associate, group health plan, or administrator * law enforcement agency * Social Security Administration * agency, organization, or entity administering a benefits program * educational, vocational, or rehabilitation organization, financial institution, bank, accountant, tax preparer, attorney, or * other persons or institutions.

TO PROVIDE THE FOLLOWING INFORMATION TO COMPANY OR ITS AUTHORIZED REPRESENTATIVES:
- My complete patient file and entire medical record including any charts, notes, x-rays, operative reports, lab, and medication records, copies of all prescriptions, and all other medical information about me including my medical history, diagnosis, testing, and test results, consultation reports, prognosis, and treatment of any physical condition, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes, communicable disease or disorders, sexually transmitted disease, mental, psychiatric, or psychological condition including test results, drug, alcohol, or other substance abuse including treatment or therapy;
- Non-medical information about me, including information concerning my education, occupation, employment history, earnings, finances, unemployment benefits, applications for insurance, or eligibility for other benefits;
- Social Security information concerning me, including detailed information regarding earnings for up to ten (10) years, and/or a summary record of total earnings, and/or information from master benefits records regarding the award, denial, or continuation of benefits.

I UNDERSTAND, ACKNOWLEDGE, AND AGREE TO THE FOLLOWING PROVISIONS:
No Restrictions: Any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct the persons or organizations identified in paragraph two (2) above to release and disclose my entire medical record without restriction. **Purpose**: The Company will use the information to (1) properly evaluate my claim and determine my eligibility for coverage; and (2) conduct other legally permissible activities. **Use**: In the course of conducting its business, the Company may disclose to other parties information about me. The Company may release this information about me to affiliates, reinsurers, MIB, LLC and any person performing business or legal services for the Company. The information disclosed pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule and may be redisclosed pursuant to this Authorization or otherwise as permitted or required by law. **Right to Revoke**: I have the right to revoke this Authorization at any time by sending a written statement to the Company, Credit Insurance Claims Department, P.O. Box 4328, Springfield, MO 65808-4328, except to the extent it has been relied upon to disclose requested records. **Expiration**: This authorization is valid for two (2) years from the date below or the duration of this claim, whichever period is shorter. **Copy**: My authorized representative or I have a right to receive a copy of this Authorization. A photocopy or facsimile of this authorization is as valid as the original. I understand that if I refuse to sign this authorization to release my complete medical records, the Company may not be able to process benefit payments requested under my policy.

I understand any false statement made knowingly and willfully to obtain information from federal records is punishable by fine, imprisonment, or both.

SIGNATURE OF INSURED OR PERSONAL REPRESENTATIVE	DATE	IF REPRESENTATIVE, GIVE RELATIONSHIP

PRINT NAME OF INSURED	DATE OF BIRTH	SOCIAL SECURITY NUMBER

POLICY/CERTIFICATE NUMBER