American Bankers Life Assurance Company of Florida
Time Insurance Company
P.O. Box 977122, Miami, FL 33197-7122 • 1.800.859.0490 • Fax 305.252.6910
Attn: DFS Claims Department

DISABILITY CLAIM FORM

All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

AFTER 30 CONSECUTIVE DAYS OF DISABILITY (Example: Disabled 01/01/12, complete form after 02/01/12)

☐ **1. Complete Section 1.**
- ☐ **If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.**
- ☐ **If you are self-employed attach a copy of your business license.**
- ☐ **Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which your disability started.**

☐ **2. Have your doctor complete Section 2.**

- To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.
- If your claim is approved, a continuing claim form must be submitted every 30 days for additional payments to be made.

Fax completed form and all supporting documentation to 305.252.6910 or mail to:

DFS Claims Department
PO Box 977122
Miami FL 33197-7122

ONCE YOUR CLAIM IS RECEIVED

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

For your protection **Arizona** law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA residents Only: 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.

CO residents only: 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. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC residents only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL residents only: 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.

KY residents only: Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance 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. **HIGH LIMIT AD** - No statements made by the applicant may be changed without his written consent.

MD residents only: 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.

NJ residents only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM residents only: 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.

OK residents only: 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.

PA residents only: 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.

RI residents only: 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.

TX residents only: 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.

VA residents only: *This notice is not applicable to life and health insurance.

WA residents only: 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.

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WWW.BENEFITACTIVATIONS.COM

DISABILITY CLAIM FORM

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SECTION 1 - CLAIMANT'S INFORMATION **PLEASE PRINT**

NAME OF FINANCIAL INSTITUTION OR STORE THAT ISSUED CREDIT CARD	CREDIT CARD - ACCOUNT NUMBER

NAME OF PRIMARY CARDHOLDER	DATE OF BIRTH	PLACE OF EMPLOYMENT	HOURS WORKED PER WEEK
	/ /		
NAME OF CLAIMANT	DATE OF BIRTH	PLACE OF EMPLOYMENT	HOURS WORKED PER WEEK
	/ /		

CLAIMANT'S JOB TITLE	DATE HIRED
	/ /

TYPE OF EMPLOYMENT	LAST DAY YOU WORKED	DATE YOU RETURNED TO WORK
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary ☐ Self-Employed	/ /	/ /

HAVE YOU RESUMED DUTIES	NUMBER OF HOURS PER WEEK
☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time	

ARE YOU RETIRED	IF YES, DATE RETIRED	REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT
☐ Yes ☐ No	/ /	

CLAIMANT'S STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)
( )	( )	

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization, or person having any records, data, or information concerning this claim to furnish such record, data, or information to the insurance company issuing my policy. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If, in fact, the furnished information is false, thereby inducing payment of claim, and the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give the insurance company issuing my policy the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall remain valid for the duration of the claim.

WARNING: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties. **For state specific Fraud Statements, see page 2.**

CLAIMANT'S SIGNATURE	CLAIMANT'S SOCIAL SECURITY NUMBER	DATE
X	- -	/ /

SECTION 2 - DOCTOR'S STATEMENT

PLEASE PRINT

(to be furnished without expense to the Insurance Company)

PATIENT'S FULL NAME

DIAGNOSIS (CODE(S))
☐ ICD-9_____ ☐ CPT_____ ☐ DSM III_____

CURRENT DIAGNOSIS

LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)
FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation

GIVE EXACT DATES OF PARTIAL DISABILITY
FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT
☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled

IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED
☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)

☐ Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)
☐ Class 2 - Medium manual activity. (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

IS CONDITION DUE TO PREGNANCY
☐ Yes ☐ No

IF YES, DESCRIBE COMPLICATIONS

ESTIMATED DATE OF DELIVERY
/ /

WHEN DID SYMPTOMS FIRST APPEAR
/ /

WAS DISABILITY CAUSED BY AN ACCIDENT
☐ Yes ☐ No

IF YES, DATE OF ORIGINAL ACCIDENT
/ /

IF YES, DESCRIBE ACCIDENT

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION
☐ Yes ☐ No

GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)

DESCRIBE SAME OR SIMILAR CONDITION

GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)

DATES OF TREATMENT
FIRST VISIT / / LAST VISIT / / NEXT VISIT / /

FREQUENCY OF VISITS
☐ Weekly ☐ Monthly ☐ Other (specify) _____

HAS PATIENT BEEN HOSPITALIZED
☐ Yes ☐ No If yes, FROM / / THROUGH / /

NAME OF HOSPITAL

STREET ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( )

DID PATIENT HAVE SURGERY
☐ Yes ☐ No

IF YES, DESCRIBE SURGERY

DATE PERFORMED
/ /

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION
☐ Yes ☐ No

IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK / /

IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK
/ /

PROGNOSIS/COMMENTS (HAS PATIENT PROGRESSED)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

STREET ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( ) | FAX NUMBER ( )

ATTENDING PHYSICIAN'S NAME (PLEASE PRINT)

ATTENDING PHYSICIAN'S SIGNATURE
X

MEDICAL ID NUMBER | DEGREE | DATE / /

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE