## LIFE ASSURANCE COMPANY

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CREDIT DISABILITY CLAIM

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing any false, incomplete, misleading, or deceptive statement is guilty of an insurance fraud.

V/ -	NAME OF INSURED LOAN #						
EN	IAME OF CREDITOR BENEFICIARY (Where payments are due)						
ΕÄ							
	ADDRESS OF CREDITOR	CITY OR TOWN		STATE	ZIP CODE		TEL#
ST/S		EFFECTIVE DATE				_	
	POLICY WAS PURCHASED	O AT		CREDITOR STATEMENT (	COMPLETED BY		
	PATIENT'S NAME			DIAGNOSIS	S OF DISABILITY		
		RESENTED					
AT ans)	HAS PATIENT EVER HAD SA	HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?					
EMENT physicians	DATE AND TYPE OF SURGERY DATES OF HOSPITAL CONFINEMENT						
ᄪᇸ	WAS PATIENT TOTALLY DISA	ABLED FROM USUAL OCCUPATION	N? YES	NO DISABLED FROM	M ANY OCCUPATION	N? YES	S NO
STATI e treating	DATES OF TOTAL DISABILIT	ΓY: FROM TO	D/	TES OF PARTIAL DISABILIT	ΓY: FROM	TO	
ST		FICE VISITS FOR THIS DISABILITY					
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PHY:							
<b>≖</b> €				DATE SIGNED			
	PHYSICIAN'S ADDRESS	Cl	TY OR TOWN	STATE	ZIP CODE	E	TEL #
늘	COMPANIVALANE			-	DATE OF LUDE		
EMPLOYER'S STATEMENT (To be completed by emplover)	COMPANY NAME	FIRST DATE RE	TUDNED	L	DATE OF HIRE	TV A\/AII A	\DI E2
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E T	ADDRESS OF EMPLOYER			CITY OR TOWN	ST	TATE	ZIP CODE
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## **CLAIM INSTRUCTION SHEET**

Please find the enclosed claim form you requested. As you will see, there is a section for your creditor's statement(you may complete this yourself), your physician's statement, your employer's statement, and your statement(claimant). All portions of this claim should be completed in full in order to process the claim. If you have difficulty completing the creditor statement, you may refer to your certificate of insurance. An incomplete form may cause a delay in processing.

## **EXPLANATION OF CREDITOR'S STATEMENT**

1.	NAME OF INSURED	PERSON WITH INSURANCE COVERAGE
		YOUR ACCOUNT NUMBER WITH YOUR CREDITOR
3.	NAME OF CREDITOR BENEFICIARY	WHO DID YOU FINANCE THE LOAN THROUGH
4.	CREDITOR ADDRESS	WHERE YOU SEND YOUR PAYMENTS
5.	POLICY#	CREDIT INSURANCE CERTIFICATE NUMBER
6.	EFFECTIVE DATE	DATE YOU MADE PURCHASE
7.	ORIGINAL AMT. OF INS	ORIGINALS \$ AMOUNT OF INSURANCE COVERAGE
8.	MO. BEN	MONTHLY AMOUNT OF INSURANCE COVERAGE
9.	POLICY PURCHASED AT	WHERE INSURANCE PURCHASED
10.	COMPLETED BY	SIGNATURE OF PERSON COMPLETING SECTION

\*\*\*Below are some answers to often asked questions to help you better understand the procedure when filing a disability claim. When you have completed your claim form and are ready to mail it please verify the address you are mailing. (Life Assurance Company, P.O. Box 20667, Oklahoma City, OK 73156) It is a good idea to keep a copy of the claim form and the instruction sheet handy for future reference. We recommend that you always mail the form directly to the insurance company yourself and not depend on any other company or person to do so for you.

- You must be off work due to disability for a specified waiting period before you are entitled to benefits.
   Consult your insurance policy in order to find out the number of days your waiting period would be. <u>Keep in mind</u>, do not start the claim process until your waiting period has been met. If there are circumstances that pertain to your claim which cannot be explained on your form, attach your written statement to the claim. <u>MAKE SURE YOUR FORM IS FILLED OUT CLEARLY AND COMPLETELY AND KEEP IN MIND THAT ILLEGIBLE OR INCOMPLETE FORMS MAY CAUSE DELAY IN PROCESSING.</u>
- 2. We recommend that you do not mail your employer or doctor the form in order to have them complete their statements. Take them in person and wait for it to be filled out and signed <u>if possible</u>. If it isn't possible for you to deliver the form, send a letter with the form explaining what you need and have them mail the form back to you. **DO NOT** depend on a physician or an employer to mail it to the insurance company. **YOU** are responsible for getting the form completed throughout the duration of your disability term and getting them to the insurance company. These completed forms are needed periodically to confirm continued disability.
- 3. The initial review of your claim will be done as soon as possible upon receipt of the necessary information. If the form is incomplete, illegible, or additional information has to be requested, the sooner the information is provided the sooner we will be able to process your claim. Until the insurance company settles the claim, you are responsible for your loan payment. When a claim is paid, a check will be issued directly to your creditor and you will receive a copy of such payment.

IF YOU HAVE ANY QUESTIONS, DO NOT HESITATE TO CALL 1-800-522-1314.