

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

AFTER 30 CONSECUTIVE DAYS OF DISABILITY
(Example: Disabled 01/01/2010, complete form after 02/01/2010)

1. Complete Section 1.
 - a. If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
 - b. If you are self-employed attach a copy of your business license.
2. Have your doctor complete Section 3.
3. Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including the top portion) for the month in which your disability started.

Mail completed form and all supporting documentation 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.

Union Security Life Insurance Company of New York

Administrative Office
P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085
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.

INSTRUCTIONS

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 1/1/10, complete form after 2/1/10)

- 1. Complete Section 1.
 - a. If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
 - b. If you are **self-employed** attach a copy of your **business license**.
- 2. Have **your doctor** complete Section 2.
- 3. **Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which your disability started.**

FAILURE TO COMPLETE REQUIRED SECTIONS AND PROVIDE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.

- 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.
- After mailing your claim, please allow 15 business days for processing.

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DISABILITY CLAIM FORM

SECTION 1 - CARDHOLDER'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 <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Self-Employed		LAST DAY YOU WORKED / /	DATE YOU RETURNED TO WORK / /
HAVE YOU RESUMED DUTIES <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		NUMBER OF HOURS PER WEEK	
ARE YOU RETIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE RETIRED / /	REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT	
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.

CLAIMANT'S SIGNATURE X	CLAIMANT'S SOCIAL SECURITY NUMBER - -	DATE / /
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SECTION 2 - DOCTOR'S STATEMENT

PLEASE PRINT

(to be furnished without expense to the Insurance Company)

PATIENT'S FULL NAME		DIAGNOSIS (CODE(S)) <input type="checkbox"/> ICD-9 _____ <input type="checkbox"/> CPT _____ <input type="checkbox"/> DSM III _____	
CURRENT DIAGNOSIS			
LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS			
GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK) <input type="checkbox"/> His/Her Occupation FROM / / TO / / <input type="checkbox"/> Any Occupation		GIVE EXACT DATES OF PARTIAL DISABILITY <input type="checkbox"/> His/Her Occupation FROM / / TO / / <input type="checkbox"/> Any Occupation	
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT <input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-Disabled		IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Longer than 9 months <input type="checkbox"/> Undetermined	
PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE) <input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity. (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)			
IS CONDITION DUE TO PREGNANCY <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DESCRIBE COMPLICATIONS		ESTIMATED DATE OF DELIVERY / /
WHEN DID SYMPTOMS FIRST APPEAR / /	WAS DISABILITY CAUSED BY AN ACCIDENT <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, DATE OF ORIGINAL ACCIDENT / /
IF YES, DESCRIBE ACCIDENT			
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____	
HAS PATIENT BEEN HOSPITALIZED <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, FROM / / THROUGH / /		NAME OF HOSPITAL	
STREET ADDRESS		CITY	STATE
		ZIP CODE	TELEPHONE NUMBER ()
DID PATIENT HAVE SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DESCRIBE SURGERY		DATE PERFORMED / /
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION <input type="checkbox"/> Yes <input type="checkbox"/> 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