

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

1. Have Section A completed by your creditor or by the financial institution where the coverage was purchased.
2. If this is a revolving account, have creditor provide print out showing amount due on the date of disability.
3. If premiums are paid monthly, please submit a Statement of Account for the month in which disability occurred.
4. Complete Section B.
If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
5. Have your employer complete Section C.
6. Have your doctor complete Section D.
7. Attach a copy of your Certificate of Insurance (including health questions) and Application for Credit Insurance if applicable.
8. Complete attached Health Insurance Portability and Accountability Act (HIPAA) Authorization.
9. Follow your creditor's instructions for mailing the completed claim form.

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

INITIAL CREDIT/CLOSED END MONTHLY OUTSTANDING BALANCE DISABILITY CLAIM FORM

All benefit payments are paid directly to your creditor.

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.)

- 1. Have Section A completed by your creditor or by the financial institution where the coverage was purchased.
- 2. Complete Section B.
If you are receiving Social Security Disability, please provide us with a copy of your award letter or certification that you are receiving SSDI.
Complete attached Health Insurance Portability and Accountability Act (HIPAA) Authorization (Page 5).
- 3. Have your employer complete Section C.
- 4. Have your doctor complete Section D.
- 5. **Have Creditor attach a copy of your Certificate of Insurance (including health questions) and Application for Credit Insurance if applicable.**
- 6. If this is a revolving account, have creditor provide print out showing amount due on date of disability.

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.

A. CREDITOR'S INFORMATION		(ATTACH A PHOTOCOPY OF POLICY/CERTIFICATE)			PLEASE PRINT	
POLICY/CERTIFICATE # (INCLUDE PREFIX)	DATE OF ISSUE / /	TERM IN MONTHS	AGENT CODE	BRANCH NO.	CLAIM NUMBER	
ACCOUNT # / LOAN #	DUE DATE / /	POLICY EXPIRES / /	A&H COVERAGE <input type="checkbox"/> Retro _____ Days <input type="checkbox"/> Retro _____ Days		FORM # OF POLICY/CERTIFICATE	
WERE HEALTH QUESTIONS USED <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a copy of completed application.						
WAS THIS LOAN REFINANCED <input type="checkbox"/> Yes <input type="checkbox"/> No		PREVIOUS LOAN #	PREVIOUS POLICY # / CERTIFICATE #			
DATE OF ISSUE / /	EXPIRATION DATE / /	PREVIOUS MONTHLY BENEFIT \$		PREVIOUS TERM		
MONTHLY BENEFIT \$	NAME OF DEALER OR BRANCH WHERE INSURANCE WAS PURCHASED					
FIRST BENEFICIARY/CREDITOR				TELEPHONE NUMBER ()		
STREET ADDRESS		CITY		STATE	ZIP CODE	
NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)		SIGNATURE X		DATE / /		

B. CLAIMANT'S STATEMENT FOR ACCIDENT OR SICKNESS CLAIM**PLEASE PRINT**

NAME OF FINANCIAL INSTITUTION (WHERE PAYMENT IS TO BE MADE)				CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	
FULL NAME OF CLAIMANT					DATE OF BIRTH / /
STREET ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE NUMBER ()
WHAT IS YOUR USUAL OCCUPATION			DESCRIBE YOUR USUAL JOB DUTIES		
WERE YOU EMPLOYED WHEN DISABILITY BEGAN <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, LAST DATE WORKED / /	GIVE EXACT REASON FOR YOUR UNEMPLOYMENT		
ARE YOU RETIRED <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, DATE RETIRED / /	REASON FOR RETIREMENT		
NAME, ADDRESS AND PHONE NUMBER OF THE EMPLOYER YOU WERE WORKING FOR WHEN YOUR DISABILITY BEGAN (IF UNEMPLOYED WHEN DISABILITY BEGAN, STATE NAME, ADDRESS AND PHONE NUMBER OF LAST EMPLOYER)					
DISABILITY CAUSED BY <input type="checkbox"/> Accident <input type="checkbox"/> Sickness		DATE ACCIDENT HAPPENED OR DATE SICKNESS BEGAN / /	DESCRIBE YOUR SICKNESS OR INJURY		
ON WHAT DATE WERE YOU FIRST TREATED BY A PHYSICIAN FOR THIS SICKNESS OR INJURY / /		GIVE NAME OF PHYSICIAN		TELEPHONE NUMBER ()	
LIST ALL DOCTORS, CLINICS, AND HOSPITALS WHICH TREATED YOU IN THE PAST FIVE YEARS, FOR ANY INJURY, ILLNESS OR GENERAL CHECK-UPS -- INCLUDE COMPLETE ADDRESS AND PHONE NUMBER (ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)					
ARE YOU NOW RECEIVING OR HAVE YOU APPLIED FOR: (IF YES, ATTACH A COPY OF THE AWARD LETTER) Social Security Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Other Disability Benefits _____					DATE OF ENTITLEMENT / /
GIVE FIRST DATE YOU DID NOT WORK BECAUSE OF THIS SICKNESS OR INJURY / /		DATE YOU RETURNED TO WORK PART-TIME / /	DATE YOU RETURNED TO WORK FULL-TIME / /	NUMBER OF HOURS PER DAY	
IF YOU HAVE RETURNED TO WORK PART-TIME, DESCRIBE THE DUTIES YOU ARE ABLE TO PERFORM					

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 as requested. 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 be 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	SOCIAL SECURITY NUMBER - -	DATE / /
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C. EMPLOYER'S STATEMENT						(MUST BE FULLY COMPLETED)						PLEASE PRINT														
TO BE COMPLETED BY YOUR EMPLOYER OR UNION REPRESENTATIVE																										
NAME OF EMPLOYEE						DATE HIRED			DATE LAST WORKED PRIOR TO DISABILITY																	
EMPLOYEE WAS ABSENT FROM JOB DUE TO						EMPLOYEE'S OCCUPATION/JOB TITLE																				
<input type="checkbox"/> Accident <input type="checkbox"/> Sickness																										
HAS EMPLOYEE RETURNED TO WORK						WHAT DATE DID EMPLOYEE RESUME PARTIAL DUTIES			WHAT DATE DID EMPLOYEE RESUME FULL DUTIES																	
<input type="checkbox"/> Yes <input type="checkbox"/> No						/ /			/ /																	
NAME OF EMPLOYER						TELEPHONE NUMBER			FAX NUMBER																	
						()			()																	
STREET ADDRESS						CITY			STATE			ZIP CODE														
COMPLETED BY (PRINT NAME)						SIGNATURE			DATE																	
						X			/ /																	
D. DOCTOR'S STATEMENT						(TO BE FURNISHED WITHOUT EXPENSE TO THE INSURANCE COMPANY)						PLEASE PRINT														
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)									GIVE EXACT DATES OF PARTIAL DISABILITY																	
FROM / / TO / /									FROM / / TO / /																	
<input type="checkbox"/> His/Her Occupation <input type="checkbox"/> Any Occupation									<input type="checkbox"/> His/Her Occupation <input type="checkbox"/> Any Occupation																	
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT												IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED														
<input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-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			IF YES, DESCRIBE COMPLICATIONS									ESTIMATED DATE OF DELIVERY														
<input type="checkbox"/> Yes <input type="checkbox"/> No												/ /														
WHEN DID SYMPTOMS FIRST APPEAR			WAS DISABILITY CAUSED BY AN ACCIDENT									IF YES, DATE OF ORIGINAL ACCIDENT														
/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No									/ /														
IF YES, DESCRIBE ACCIDENT																										
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION						GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)																				
<input type="checkbox"/> Yes <input type="checkbox"/> No																										
DESCRIBE SAME OR SIMILAR CONDITION																										
GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)																										
DATES OF TREATMENT												FREQUENCY OF VISITS														
FIRST VISIT / / LAST VISIT / / NEXT VISIT / /												<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____														
HAS PATIENT BEEN HOSPITALIZED												NAME OF HOSPITAL														
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, FROM / / THROUGH / /																										
STREET ADDRESS			CITY			STATE			ZIP CODE			TELEPHONE NUMBER														
												()														
DID PATIENT HAVE SURGERY			IF YES, DESCRIBE SURGERY									DATE PERFORMED														
<input type="checkbox"/> Yes <input type="checkbox"/> No												/ /														
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION						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														
<input type="checkbox"/> Yes <input type="checkbox"/> No						/ /						/ /														
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						MEDICAL ID NUMBER			DEGREE			DATE								
						X												/ /								
FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE																										

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Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following information to Union Security Life Insurance Company of New York.

INSURED INFORMATION			
NAME	SOCIAL SECURITY NUMBER - -	BIRTH DATE / /	DAYTIME TELEPHONE NUMBER ()
STREET ADDRESS	CITY	STATE	ZIP CODE
MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION:			
NAME	TELEPHONE NUMBER ()		
STREET ADDRESS	CITY	STATE	ZIP CODE
DESCRIPTION OF INFORMATION TO BE RELEASED			
ENTIRE MEDICAL RECORD <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER			
I UNDERSTAND THAT:			
a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization.			
b. 1. This Authorization will expire without any action by me one year after the date of my signing below. 2. This Authorization shall be valid for the duration of the claim (Arizona residents only).			
c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.			
d. This authorization is voluntary and I have the right to refuse to sign it.			
e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.			
f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.			
g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.			
h. I agree that a photocopy of this authorization shall be as valid as the original.			
i. I, or my authorized representative, have the right to receive a copy of this authorization.			
YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE) X			DATE / /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MAY BE REQUIRED)
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ONE FORM MUST BE COMPLETED FOR EACH MEDICAL PROVIDER
Please photocopy this form if you need additional copies.