American Bankers Life Assurance Company of Florida

P.O. Box 977122, Miami, FL 33157 • 1.800.327.5288 • Fax 1.305.252.6910

APPLICATION FOR DISABILITY BENEFITS

Mail or fax completed form and any attachments to 1.305.252.6910

INSTRUCTIONS

A CLAIM REPORT MUST BE FULLY COMPLETED BY THE ATTENDING PHYSICIAN, EMPLOYER, AND THE INSURED AT THE END OF EACH 30-DAY PERIOD OF DISABILITY, OR WHEN THE INSURED RESUMES WORK, WHICHEVER OCCURS FIRST. RETURN THIS FULLY COMPLETED REPORT TO THIS COMPANY AT THE ADDRESS ABOVE. YOUR CLAIM MAY BE DELAYED IF ALL PARTS ARE NOT FULLY COMPLETED.

PLEASE ATTACH A COPY OF THE CERTIFICATE.

CREDITOR'S STATEMENT (to be completed by the Creditor's Office) PLEASE PRINT

NAME OF INSURED DEBTOR	LOCATION OR AGENT NUMBER	CERTIFICATE OF POLICY NUMBER

BANK NAME	TELEPHONE NUMBER
	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

CUSTOMER ACCOUNT NUMBER	EFFECTIVE DATE	PAYMENT DUE DATE	TERM IN MONTHS	MONTHLY PAYMENT AMOUNT
	/ /	/ /		$

NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE	DATE
	X	/ /

CLAIMANT'S STATEMENT (to be completed and signed by Claimant) PLEASE PRINT

FULL NAME OF CLAIMANT (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	OCCUPATION
	/ /	

STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

NAME OF EMPLOYER	TELEPHONE NUMBER
	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

NATURE OF ILLNESS	DATE LAST WORKED	IF ILLNESS, GIVE DATE IT BEGAN
	/ / HOUR	/ /

IF ACCIDENT, GIVE DATE AND TIME	WHERE AND HOW DID ACCIDENT OCCUR
/ / HOUR	

DESCRIBE INJURIES

NAME OF PRIMARY CARE PHYSICIAN	TELEPHONE NUMBER
	( )

HAVE YOU HAD SAME OR SIMILAR ILLNESS BEFORE	IF "YES," WHEN
☐ Yes ☐ No	/ /

NAME OF DOCTOR	STREET ADDRESS	CITY	STATE	ZIP CODE	DATE FIRST CONTACTED
					/ /
NAME OF DOCTOR	STREET ADDRESS	CITY	STATE	ZIP CODE	DATE FIRST CONTACTED
					/ /

STATE DATES YOU WERE TOTALLY DISABLED AND ABSENT FROM WORK	STATE DATE YOU RETURNED TO WORK	**OR** DATE YOU EXPECT TO RESUME WORK
FROM / / TO / /	/ /	/ /

I certify the foregoing statements are true and correct to the best of my knowledge and belief, without evasion or reservation.

AUTHORIZATION TO RECEIVE INFORMATION: I authorize all doctors, pharmacists, hospitals, druggists, Veterans Administration facility, or other medical related facility, institutions or persons rendering care and treatment to furnish the requesting insurance company or its representatives with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or insurance carrier to release information for:

NAME	DATE OF BIRTH
	/ /

STREET ADDRESS	CITY	STATE	ZIP CODE

to Summit Administrators, Inc. 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 this claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I UNDERSTAND the information will be used by the requesting insurance company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. THIS authorization is valid from the date signed for the duration of the claim.

I ALSO authorize the requesting insurance company or its authorized representatives to disclose the information for the purposes of evaluating and administering a claim for benefits to any reinsurer and to any other insurance company or self-insurers to whom a claim for benefits may be submitted.

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

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

See Fraud Statement on reverse side of form.

DOCTOR'S STATEMENT (to be furnished without expense to the insurance company) PLEASE PRINT

NOTE TO PHYSICIAN

Since this insurance is designed to provide benefits for installment payments, please supply the information required on the form as soon as possible. Your prompt compliance will be greatly appreciated by both your patient and the company.

PATIENT'S NAME

DIAGNOSIS

(A) PRIMARY

(B) CONTRIBUTORY CAUSES OF DISABILITY

(C) COMPLICATIONS

(D) DID PATIENT HAVE SURGERY ☐ Yes ☐ No | IF YES, DESCRIBE

(E) IS DISABILITY DUE TO PREGNANCY ☐ Yes ☐ No | IF YES, ESTIMATED DATE OF DELIVERY / /

(F) HAS PATIENT BEEN HOSPITALIZED ☐ Yes ☐ No FROM / / THROUGH / / | NAME OF HOSPITAL

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

HISTORY

WHEN DID SYMPTOMS FIRST APPEAR / / | WAS DISABILITY CAUSED BY AN ACCIDENT ☐ Yes ☐ No | IF YES, DATE OF ORIGINAL ACCIDENT / /

DATE PATIENT CEASED WORK BECAUSE OF DISABILITY/ACCIDENT / / | HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION ☐ Yes ☐ No | IF YES, DATE / /

DESCRIBE SAME OR SIMILAR CONDITION

TREATMENT

INITIAL DATE OF TREATMENT / / | LAST DATE OF TREATMENT / / | FREQUENCY OF VISITS ☐ Weekly ☐ Monthly ☐ Other

EXTENT OF DISABILITY

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

PROGNOSIS

HAS PATIENT PROGRESSED ☐ Yes ☐ No | PROGRESS ☐ Improved ☐ Recovered ☐ No Change ☐ Retrogressed

ESTIMATE DATE PATIENT CAN RETURN TO WORK / / | IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION ☐ Yes ☐ No | IF NO, DATE PATIENT WAS RELEASED / / | ANY LIMITATIONS ☐ Yes ☐ No

NAME OF REFERRING PHYSICIAN IF ANY | TELEPHONE NUMBER ( )

STREET ADDRESS | CITY | STATE | ZIP CODE

"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."

NAME OF ATTENDING PHYSICIAN (Please print) | ATTENDING PHYSICIAN'S SIGNATURE X | TAX ID NUMBER | DATE / /

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

EMPLOYER'S STATEMENT (must be fully completed) PLEASE PRINT

NAME OF EMPLOYEE | EMPLOYEE WAS AWAY FROM WORK BEGINNING / / ☐ AM ☐ PM THROUGH / / ☐ AM ☐ PM

ORIGINAL DATE OF EMPLOYMENT / / | IF EMPLOYEE WAS TERMINATED, GIVE DATE / / | IF DISABILITY IS DUE TO SICKNESS, WAS EMPLOYEE PREVIOUSLY AFFLICTED WITH THIS ILLNESS ☐ Yes ☐ No

IS DISABILITY DUE TO EMPLOYMENT ☐ Yes ☐ No | IF YES, DATE OF INJURY / / | DESCRIPTION OF DUTIES

HOW DO YOU DESCRIBE THESE DUTIES ☐ Light ☐ Medium ☐ Heavy | DO YOU HAVE LIGHT DUTY AVAILABLE ☐ Yes ☐ No | IF YES, AS OF WHAT DATE / /

NAME OF EMPLOYER | TELEPHONE NUMBER ( )

STREET ADDRESS | CITY | STATE | ZIP CODE

COMPLETED BY (PRINT NAME) | SIGNATURE X | POSITION | DATE / /

FL residents only: Pursuant to § 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in § 775.082, § 775.083, or § 775.084, Florida Statutes.

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.

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.

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.