American Bankers Life Assurance Company of Florida

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

CONTINUING DISABILITY CLAIM FORM

Mail or fax completed form and any attachments to 1.305.252.6910.

INSTRUCTIONS

1. **Complete Section A.**
2. **Have your Doctor complete Section B.**

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

- **After faxing or mailing your claim, please allow 15 business days for processing.**
- **Please include your claim number on all correspondence sent to our office.**
- **The status of your claim may be verified by calling 1.800.327.5288.**
- **New charges made to your account during a claim period are not covered and will not be paid.**
- **A claim form must be submitted with updated verification every 30 days for additional payments to be made.**

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.

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.

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CONTINUING DISABILITY CLAIM FORM

A. CLAIMANT'S INFORMATION (must be completed for all claims) **PLEASE PRINT**

NAME AND ADDRESS ☐ CHECK BOX IF THIS IS A NEW ADDRESS	CLAIM NUMBER
	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)
	NAME OF FINANCIAL INSTITUTION/STORE/UTILITY COMPANY (WHERE PAYMENT IS TO BE MADE)

HAVE YOU RETURNED TO WORK SINCE YOU BECAME DISABLED	DATE RETURNED TO WORK	# OF HOURS PER WEEK
☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time	/ /	

HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY	ARE YOU RECEIVING SOCIAL SECURITY DISABILITY	**IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR SOCIAL SECURITY AWARD LETTER OR VERIFICATION THAT YOU ARE RECEIVING SSDI.**
☐ Yes ☐ No	☐ Yes ☐ No	

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 American Bankers Life Assurance Company of Florida. 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 American Bankers Life Assurance Company of Florida determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, American Bankers Life Assurance Company of Florida 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 American Bankers Life Assurance Company of Florida 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.

CLAIMANT'S SIGNATURE	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	DATE
X	- -	( )	/ /

B. DOCTOR'S STATEMENT (to be furnished without expense to the Insurance Company) **PLEASE PRINT**

PATIENT'S FULL NAME	DIAGNOSIS (CODE(S))
	☐ ICD-9_____ ☐ CPT_____ ☐ DSM III_____

CURRENT DIAGNOSIS	LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS (ATTACH A SEPARATE SHEET IF NECESSARY)

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)	**GIVE EXACT DATES OF PARTIAL DISABILITY**
FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation	FROM / / TO / / ☐ His/Her Occupation ☐ 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
☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled	☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

LAST TREATMENT DATE	NEXT VISIT	FREQUENCY OF VISITS
/ /	/ /	☐ Weekly ☐ Monthly ☐ Other ____________

DID PATIENT HAVE SURGERY SINCE LAST REPORT	IF SO, DESCRIBE SURGERY	DATE PERFORMED
☐ Yes ☐ No		/ /

HAS PATIENT PROGRESSED
☐ Yes ☐ No

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

"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."

PHYSICIAN'S NAME (PRINT NAME)	PHYSICIAN'S SIGNATURE	MEDICAL ID #	DEGREE	DATE
	X			/ /

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

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