Initial Credit Disability Claim Form

GUARANTEE TRUST LIFE INSURANCE COMPANY

Credit Claim Service Center
P.O. Box 1145
Glenview, IL 60025
Phone: 800-592-0629
Fax: 847-460-2962

Office Hours:
Monday thru Thursday: 7:00 A.M. to 5:00 P.M CST
Friday: 8:00 A.M. to Noon CST

Important Information

To speed processing of your claim, please attach a copy of your insurance certificate and be sure your claim form is sent to the Credit Claim Service Center after **all four (4) sections** have been completed. Incomplete data or missing signatures will delay processing your claim.

FAQS

Q. What do I send to get my claim started?

A. You need to complete the claim form accurately paying special attention to:

- Section 1: In this section, give us as much information as you can about your loan. Since we'll be sending benefits to your creditor, we need their current address and especially the loan number so they can apply the money to the right account.

- Section 2: In this section, answer every question even if you don't think it's important. If not applicable, show N/A so we know you didn't overlook the question.

- Authorization Page: Be sure to sign it after you've completed the claim form. Keep it with your claim form so your physician and employer know we have your permission for them to answer our questions.

- Have your Employer and Doctor complete their portions of the form.

Please send the completed claim form to our mailing address shown above. We'll take care of everything when we get it.

(Please see the reverse side for additional information.)

Q. When will my benefits begin? Should I continue to make payments?

A. Your loan agreement with your creditor is separate from your contract with us. There are many factors we don't control particularly how long it takes to get the requested proofs of loss. While we try our best to schedule payments to coincide with your loan due date, that's not always possible. It's your responsibility to keep payments current to avoid late charges or other penalties that your contract with us doesn't cover.

Q. What if my physician wants to charge me for completing these forms?

A. The claim form is your proof of loss and must be provided to us without charge for us to evaluate your claim and authorize payments. Any payment the physician requires is your responsibility.

Q. What about continuing the benefits?

A. Your policy says you must be under the regular care of a physician for benefits to continue. We'll let you know with each payment what we need for the next one. It's usually a shorter form for you and your doctor to complete. We'll also tell you the date we need to have the completed form. It's important to have your form completed by the doctor as close to this date as possible.

Q. Are my benefits reduced if I am also collecting benefits from Workers Comp or Social Security Disability?

A. No. Your benefits are not related or limited by other coverage or payments made by Workers Compensation or Social Security Disability.

DETACH AND RETAIN FOR YOUR RECORDS

GTL | GUARANTEE TRUST LIFE

Guarantee Trust Life Insurance Company
P.O. Box 1145
Attn: Credit Claim Service Center
Glenview, Illinois 60025 800-592-0629

FOR GTL USE ONLY

CLAIM #: _____

Section 1 — COVERAGE AND CREDITOR STATEMENT
PLEASE ATTACH A COPY OF YOUR INSURANCE CERTIFICATE

Named Insured (Claimant)	Insurance Certificate Policy #	Monthly Payment Due Date
_____	_____	_____/_____/_____

Certificate Information ➔	Effective Date	Monthly Benefit	Term (Months)	Expiration Date	YOUR LOAN ACCOUNT NUMBER
	_____/_____/_____	$_____	_____	____/____/____	_____

Creditor/Mortgagor (Lending Institution) _____
Address _____
Street or PO Box City State Zip Code Phone Number

Reminder: Please complete all of the questions, sign & date authorization. Incomplete data will delay your claim.

Section 2 — STATEMENT OF THE INSURED

1. Insured's Name: _____ 1a. Alternate Name: _____
2. Address: _____
Street or PO Box City State Zip Code Phone Number

2a. Date of Birth _____/_____/_____ 2b. Social Security Number _____ - _____ - _____ 2c. ❑ Male ❑ Female

3. Employer's Name: _____ 3a. Address: _____
Street City State Zip Code

4. Date you last worked: _____/_____/_____ 4a. YOUR occupation at time of disability? _____
4b. YOUR job duties at time of disability were? _____

5. Describe MEDICAL CONDITION causing disability: _____
5a. When were symptoms FIRST noticed: _____/_____/_____ 5b. Is your condition due to an accident? ❑ Yes ❑ No
5c. Is your illness or accident WORK RELATED? ❑ Yes ❑ No
If "Yes," indicate initial illness or accident date: _____/_____/_____

6. Have you ever been TREATED or DISABLED by the same or similar condition before? ❑ Yes ❑ No

Physician's Name: _____	Physician's Name: _____
Physician's Address: _____	Physician's Address: _____
Physician's City, State & Zip: _____	Physician's City, State & Zip: _____
Physician's treatment dates: From: _____ To: _____	Physician's treatment dates: From: _____ To: _____

7. PRIMARY CARE PHYSICIAN Name: _____ Address: _____
Street City State Zip Code

8. **A.** If hospitalized, give dates	**A.** From: _____ To: _____	**A.** From: _____ To: _____
B. Name of each hospital	**B.** _____	**B.** _____
C. Hospital Address	**C.** _____	**C.** _____

9. Date you became TOTALLY DISABLED (Unable to work) _____/_____/_____

9a. Have you RETURNED OR BEEN RELEASED TO RETURN TO WORK? ❑ Yes ❑ No
If "Yes," give DATE RETURNED TO WORK. _____/_____/_____

I understand that this information will be used by Guarantee Trust Life Insurance Company for the purpose of evaluating my claim. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Signature: _____ Date: _____/_____/_____

Please be sure to sign the authorization on Page 3 before taking to your employer and physician.

Section 3 EMPLOYER'S STATEMENT

1. Employee's Name: _____ 2. Date Employed: _____/_____/_____
3. Date Employee last worked: _____/_____/_____ 4. Reason Employee left work: _____
5. Is this a Worker's Compensation case? Yes ❑ No ❑
   Initial date of Worker's Comp. Illness or Injury _____/_____/_____
6. Has Employee been off work due to this same condition before? Yes ❑ No ❑
   If "Yes," When? _____/_____/____
7. Job duties of Employee: _____ Classification: Light ❑ Medium ❑ Heavy ❑
8. Has Employee returned to work with you? Yes ❑ No ❑ If "Yes," date returned _____/_____/_____
9. Does Employee have a position when he/she is released? Yes ❑ No ❑
10. If Employee has been terminated, give date _____/_____/_____

EMPLOYER NAME	STREET ADDRESS	CITY	ST	ZIP	AREA CODE & PHONE	FAX NUMBER

DATE SIGNED _____/_____/_____ CERTIFIED BY_____ TITLE _____

Section 4 ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ SS#: ____-____-____ Age: _____ DOB: ____/____/_____

1. Primary medical condition causing current disability: _____
   Describe complications, or indicate any contributing infirmities: _____
2. When did symptoms first appear or accident happen: _____/_____/_____
2a. If pregnancy is causing disability is pregnancy classed as: Normal ❑ Abnormal ❑
   If "Abnormal" please give date disability began: _____/_____/_____
3. When did patient first consult you for this condition? _____/_____/_____
   First date as patient: _____/_____/_____
4. Was this patient referred to you by another physician? Yes ❑ No ❑
   If "Yes," please give physician's name and address: _____
5. List all dates of treatment for this condition: Office: _____
   Hospital: _____ Surgery: _____
6. List all dates and names of medication prescribed for this condition before and after disability inception:
   _____
7. Has patient ever been disabled or treated for same or similar condition?
   Disabled ❑ Treated ❑
   Yes ❑ No ❑ Yes ❑ No ❑ Description and date: _____
   Ongoing: Yes ❑ No ❑ Separate/Unrelated: Yes ❑ No ❑
8. Is patient still under your care for this condition? Yes ❑ No ❑ If discharged, give date: _____/_____/_____
8a. Have you referred this patient to another physician? Yes ❑ No ❑
   If "Yes," please give physician's name and address: _____
8b. Give patient's primary care physician's name and address: _____
9. As a result of your personal treatment of this patient during what period do you consider the patient to be totally and continuously disabled/restricted:
   Disabled/Restricted from own occupation From: _____ To: _____
   Disabled from other occupations: From: _____ To: _____
10. Remarks: _____
11. Actual release to return to work date: _____/_____/_____
    With restrictions ❑ Without restrictions ❑
12. Estimated return to work: ❑ Less than 6 months ❑ 6 to 12 months ❑ 12 or more months ❑ Never

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Date: _____/_____/_____ Attending Physician's Signature: _____
Physician's Name typed or printed: _____ Degree: _____
Address: _____
Street City State Zip Code
Phone Number: _____ FAX #: _____

SPDI DR 10/13

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Guarantee Trust Life Insurance Company (GTL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that Guarantee Trust Life Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by GTL in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

_____

(Print Please) Name of Patient Date of Birth

_____

Signature of Patient Date

_____

(Please Print) Name of Authorized Representative, or Next of Kin

_____

Relationship of Authorized Representative or Next of Kin to Patient

_____

Signature of Authorized Representative or Next of Kin Date

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

California
Connecticut
Georgia
Iowa
Illinois
Kansas
Louisiana
Massachusetts
Michigan
Missouri
Mississippi
Montana
North Carolina
North Dakota
Nebraska
Nevada
Puerto Rico
Rhode Island
South Carolina
South Dakota
Texas
Utah
Vermont
Wisconsin
West Virginia
Wyoming

Generic Fraud Warning **(to be used for above states only)**
Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska, Delaware, Idaho, Indiana, Oklahoma - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Colorado, Washington D.C., Hawaii, Maine, Tennessee, Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance coverage.

Arizona, Minnesota, New Jersey, New Mexico - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida - Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

Maryland, Arkansas - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Washington State - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.