SERVICE LIFE AND CASUALTY INSURANCE COMPANY
P O BOX 26800 * AUSTIN, TX 78755-0800
800-299-6977 * (512)343-0600 EXT: 3696

WE DO NOT ACCEPT FAXES

INSTRUCTIONS FOR COMPLETING A DISABILITY CLAIM FORM

There are four parts to this application that must be completed.

A: Creditor Information

This information is obtained from your payment coupon or bill. Please attach a copy of the payment coupon or bill
DO NOT SEND TO CREDITOR IT WILL CAUSE A DELAY IN PROCESSING YOUR CLAIM

B: Insured's statement for accident or sickness claim

Write legibly and complete all questions. It is important to provide a listing of physicians you have seen in the past ten years. Medical records may be requested if you are filing a claim within the first two years of the effective date of the policy.

C: Employer's Statement

This must be completed and signed by your employer. If you are self-employed, you may complete this portion, however, it will need to be notarized.

D: Doctor's statement

The treating physician who has taken you off of work is responsible for completing this portion of your application.

A delay may occur in the processing of your claim if the application is not complete with all of the necessary information.

********Please contact Service Life & Casualty at the above number and not the dealership for any assistance with your claim.***

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CLAIM FORM FOR CREDIT DISABILITY INSURANCE BENEFITS

1. To avoid late fees, continue to make your payments until you receive notification that your claim has been approved. We may need to obtain your medical records.
2. After mailing your claim form to us, please allow 10 business days for processing.
3. To check the status of your claim, after 10 business days, please call 800-299-6977.
4. Service Life does not cover the cost of reports or preparing application or proofs of loss.
5. You must be off work and under doctor's care 14 consecutive days in order to file for benefits.
6. We do not accept faxes.
7. Co-debtor is not covered for disability insurance.
8. Your physician must be licensed to practice in the U.S.A.
9. All benefit payments are paid directly to your creditor.

A. CREDITOR INFORMATION — PLEASE PRINT OR TYPE

Name of Creditor (who you pay monthly)			Disability Insurance Policy Number
Address of Creditor			
Loan/Account Number	Date you bought the vehicle / /	Payment Due Date	Monthly Payment Amount $
Have you refinanced your vehicle (lowered payments)? ☐ Yes ☐ No			If yes, give refinance date: / /
Vehicle Description	Year	Make	Model

B. INSURED'S STATEMENT FOR ACCIDENT OR SICKNESS CLAIM

Full Name of Insured (Last, First, Middle Initial)			Date of Birth	Sex	Height	Weight
Physical Address/Apt. No. and Mailing Address	City	State	Zip	Telephone Number: ( )		

Describe your illness/accident:		
Date illness/accident happened / /	What day did you stop working? / /	What day did you return to work? / /

List all Doctors, Clinics, and Hospitals which treated you in the past ten years, ***for any injury, illness or general check-ups.*** **Include complete address and phone number starting with the doctor you saw for this condition. (Attach a separate sheet if additional space is needed)** ***If the section below is left blank, the form will be returned to you for completion.***

Name of Doctor	Phone No & Address	Month & Year of Visit	Reason Seen

I HEREBY WARRANT THAT THE ABOVE STATEMENTS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE DOCTOR, HOSPITAL, GOVERNMENT AGENCY, INSURANCE COMPANY, CREDIT AGENCY OR ORGANIZATION TO RELEASE TO SERVICE LIFE AND CASUALTY INFORMATION REGARDING MY MEDICAL HISTORY/TREATMENT, INCLUDING BUT NOT LIMITED TO AIDS, HIV, ALCOHOL, DRUG AND PSYCHIATRIC TREATMENT AND PAST AND PRESENT EMPLOYMENT STATUS DURING THE COURSE OF MY CLAIM.
IN ADDITION, I AUTHORIZE SERVICE LIFE AND CASUALTY TO REQUEST A REPORT FROM THE HEALTH CLAIMS INDEX (HCI), WHICH IS OPERATED BY THE MEDICAL INFORMATION BUREAU (MIB), WHICH IS AN ASSOCIATION OF LIFE INSURANCE COMPANIES THAT OPERATES THE HIC ON BEHALF OF SUBSCRIBER INSURERS. I UNDERSTAND THAT THE COMPANY MAY ALSO SEND A BRIEF REPORT TO HCI, AN HCI REPORT INCLUDES THE DATES OF CLAIMS FILED BY ME, CLAIM DATE OF LOSS, AND THE NAMES OF COMPANIES TO WHICH CLAIMS WERE SENT, BUT DOES NOT CONTAIN MEDICAL INFORMATION.
I UNDERSTAND THAT UPON MY REQUEST, MIB WILL DISCLOSE ANY SUCH INFORMATION TO ME. IF I QUESTION THE ACCURACY, I MAY CONTACT MIB AND SEEK A CORRECTION IN ACCORDANCE WITH THE FEDERAL FAIR CREDIT REPORTING ACT. THE ADDRESS IS MIB, INC. P.O. BOX 105, ESSEX STATION, BOSTON, MA 02112, PHONE 617-426-3660.

INSURED'S SIGNATURE____ DATE____________________

SOCIAL SECURITY NUMBER____

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

C. EMPLOYER'S STATEMENT (Must be Fully Completed) PLEASE PRINT OR TYPE

I am the employer of the named insured, and for the purpose of furnishing information to the named Insurance Company to induce payment of claim for vehicle loan of said employee, do certify:

Name of Employee	Date Hired / /	Date Last Worked Prior to Disability / /

Employee Was Absent From Job Due to ☐ Accident ☐ Sickness ☐ Worker's Comp	Employee's Occupation/Job Title

Has Employee Returned to Work ☐ Yes ☐ No	What Date Did Employee Resume Partial Duties / /	What Date Did Employee Resume Full Duties / /	Was Employee Terminated or Laid Off? / /

Workers Comp Carrier	Claim Number	Telephone Number ( )

Has Employee Been Unable to Work Due to this condition Before? ☐ Yes ☐ No If Yes, When

Name of Employer	Telephone Number ( )	Fax Number ( )

Street Address	City	State	Zip

Completed By (Print Name)	Signature	Date	Position

D. DOCTOR'S STATEMENT (To Be Furnished Without Expense to the Insurance Company)

Patient's Full Name

Is Condition Due to Pregnancy? ☐ Yes ☐ No	If Yes, Describe Complications	Estimated Date of Delivery / /

When Did Symptoms First Appear? / /	Was Disability Due to an Accident? ☐ Yes ☐ No	What Date Did You Take Patient Off Work? / /	Date of Original Accident / /

If Yes, Describe Accident

Current Diagnosis

Has Patient Been Referred By Another Doctor? If Yes, Whom:

Dates of Treatment First Visit / /	Last Visit / /	Next Visit / /	Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other (Specify)

Give All Dates of Treatment Since Onset of Condition

Has Patient Been Hospitalized? ☐ Yes ☐ No From / / Through / /	Name and Address of Hospital

Did Patient Have Surgery? ☐ Yes ☐ No	Surgery Date / /	Type of Surgery

Post Surgical Diagnosis/Prognosis

Give Exact Dates of Total Disability (Unable to Work) From / / To / /	Give Exact Dates of Partial Disability (Light Duty) From / / To / /

When Will Patient Return to Full Duty / /

"I hereby certify that the above described information is based upon reasonable probability, and is true and correct to the best of my knowledge and belief"

Attending Physician's Name (Please Print)	Address	City	State	Zip

Attending Physician's Signature	Date / /	Degree	Medical ID #	Telephone ( )	Fax Number ( )

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
******PLEASE RETURN THIS FORM BACK TO SERVICE LIFE WITH YOUR CLAIM FORM***

PLEASE COMPLETE THE BOXED AREAS ONLY

This authorization form has been specifically designed to comply with all state and federal regulations pertaining to the confidentiality of health information.

I authorize (Name of Medical and/or Healthcare Provider) ________________________________
(**do not provide names**)
to release information and/or copies of medical records for the following patient:

Patient Name:____DOB:______________

SSN:___________________________Address:____

Specific Information to be released:

__X__ER Report	__X__Discharge Summary	__X__History & Physical
__X__Consultation	______X-ray Report	__X__Pathology Report
______Lab Report	__X__Clinic/Progress Note	__X__Operative Report

Dates of Treatment (s): ________________ to ________________(**do not provide dates**)

Purpose of Disclosure: _________Application for Credit Life/Disability Benefits________

I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ______ Initial

Records are to be released to Service Life and Casualty Insurance Company, PO Box 26800, Austin, TX 78755

This authorization is valid for 180 days from date of signing and may be revoked at any time by sending a written request to the provider named above prior to the expiration date. Revocation of this authorization shall not affect releases of information made prior to the revocation. I understand that authorizing the disclosure of my protected health information is voluntary. I further understand that the disclosure of this information carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by Federal Confidentiality Rules.
I understand that my treatment at the above healthcare provider/medical facility will not be affected if I decide not to sign this authorization.

Patient's Signature________________________________ Date_______________

Patient's Printed Name____

Copies of this original signed authorization will be considered valid and provided to all health care providers.

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CONSENT FOR COMMUNICATION

Pursuant to the Graham-Leach-Bliley Act, Service Life and Casualty Insurance Company (SLC) must adhere to certain guidelines in handling both Credit Disability and Credit Life claims. Please read each paragraph and initial that you understand and give consent for the following:

I, ____, understand that I have filed a **credit disability claim**

(   ) and hereby authorize any physician, hospital, government agency, insurance company, workers' compensation carrier or organization to release to Service Life and Casualty Insurance Company information regarding my medical history/treatment
as well as past and present employment status.

(   ) and hereby authorize my creditor

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to speak with Service Life and Casualty Insurance Company regarding my vehicle loan account.

(   ) and hereby authorize *one* other person other than myself to speak on my behalf regarding my claim with Service Life and Casualty Insurance Company. This person shall be named:

____.

PLEASE INITIAL IN THE SPACES (   ) BY EACH PARAGRAPH THAT YOU HAVE READ AND UNDERSTAND EACH CONSENT. PRINT YOUR NAME, THE NAME OF YOUR CREDITOR, AND THE NAME OF YOUR REPRESENATIVE IN THE SPACES PROVIDED.

____   ______________
Please sign your name   Date

Slc(10/06) This form shall remain valid through the life of the claim.