

SERVICE LIFE AND CASUALTY INSURANCE COMPANY

PO BOX 26800 * AUSTIN, TEXAS 78755-0800

512-343-0600 OR 800-299-6977

CREDIT INSURANCE DISABILITY CLAIM PROGRESS REPORT (CPR)

THE INSURED IS RESPONSIBLE FOR THE TIMELY COMPLETION OF THIS REPORT WITHOUT COST TO THE INSURANCE COMPANY

1. Have this form completed and returned to our office at least 7 days before your payment due date.
2. This form must be completed by a medical doctor (MD).

A. INSURED'S STATEMENT		CLAIM NUMBER:	
INSURED'S NAME		DATE OF BIRTH	
INSURED'S STREET ADDRESS, CITY, ST, ZIP		TELEPHONE NUMBER ()	
CHANGE IN ADDRESS OR PHONE NUMBER PLEASE INDICATE BELOW:			
HAVE YOU RETURNED TO WORK? (CIRCLE ONE) YES NO			
A. On what day did you return to work? _____			
B. Did you return to work? (circle one) Full Time Part Time Light Duty			
AUTHORIZATION TO OBTAIN INFORMATION			
I hereby warrant the above statements are true, correct and complete to the best of my knowledge and belief. I hereby authorize any physician, hospital, government agency, insurance company, credit agency or organization to release to Service Life and Casualty information regarding my medical history/treatment, and past and present employment status during the course of my claim.			
In addition, I authorize Service Life and Casualty or its reinsurers, to request a report from the Medical Information Bureau (MIB), which is in association of life insurance companies that operates the Health Claims Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the name(s) of the companies but does not contain medical or other personal information. I understand Service Life and Casualty may also report to MIB the date(s) of the past or present claims filed by me.			
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., PO Box 105, Essex Station, Boston, MA 02112, phone (617) 426-3660.			
_____ Signature		_____ Date	
B. ATTENDING PHYSICIAN'S STATEMENT ALL QUESTIONS MUST BE ANSWERED OR A DELAY WILL OCCUR IN PROCESSING. THIS IS STRICTLY INSURANCE FOR A VEHICLE LOAN.			
DIAGNOSIS		DATE OF MOST RECENT VISIT: _____	
COMPLICATIONS		DATE OF NEXT APPOINTMENT: _____	
PROGNOSIS			
IS INSURED UNDER YOUR CONTINUING CARE AND TREATMENT? (CIRCLE ONE) YES NO			
HAS INSURED BEEN RELEASED TO RETURN TO WORK?		DATE	DATE
LIGHT DUTY		FULL DUTY	
MEDS:		EST. SURGERY DATE.	
IS PATIENT BEING COMPLIANT?			
PRINT NAME, ADDRESS AND PHONE NUMBER OF PHYSICIAN:			
PHYSICIAN'S SIGNATURE:		REPORT DATE:	