

Reply To:

Claims Department
P.O. Box 790, Deerfield, IL 60015
1-800-841-4777

CLAIM FORM

Incomplete Forms May Cause A Delay In The Processing Of Your Claim

Claim Number

PART 1 INSURED'S STATEMENT (Altered answers are not acceptable)

When did the accident or sickness occur? _____, 20__

Where and how did it happen? _____

Date you first became unable to work due to disability _____, 20__

Date you returned to work _____, 20__
(If not, give estimated return date)

Have you had this or a similar condition before? Yes No

Name and address of doctor who treated you at that time:

Name and address of your referring family doctor:

Names, addresses and phone numbers of all physicians and chiropractors you have consulted in the past 4 years. Attach additional sheet if necessary:

Have you worked at all since you filed this claim? Yes No

If Yes, give dates worked: From _____, 20__ To _____, 20__

Are you still physically unable to work at your usual job?
 Yes No

What is your scheduled return to work date? _____, 20__

If you have returned to work,

Date you resumed light duties, _____, 20__

Date you resumed regular duties, _____, 20__

In YOUR opinion, why are you unable to do your regular job?

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION FOR EVALUATION OF CLAIM.

1. I understand that a separate form containing my authorization for the release of medical information must be completed and submitted along with this completed form.
2. By signing below, I authorize any past and/or present employer to furnish to the above insurance company or its authorized representative, any and all information regarding employment by your company, including but not limited to, a full description of your job classification, position, salary, wages, bonus plans and commissions, dates and periods of disability and subsequent earning losses.
3. I authorize the creditor/lienholder to furnish to the above insurance company or its authorized representative a copy of any and all loan/lease documentation, including but not limited to, credit application forms and loan/lease contracts.

A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain valid for 24 months following the date of my signature.

WARNING: "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 may be guilty of a crime and may be subject to civil fines and criminal penalties."

Signed _____

Date _____ Drivers License No. _____

Social Security Number _____

Mailing Address _____

Street Address _____
(no P.O. Boxes)

City _____ State _____ Zip _____

Phone () _____ Birth Date _____

Male Female

PART II LOAN INFORMATION

Disability Certificate Number _____
Effective Date _____
Payment Due Date _____ Monthly Payment _____
Loan Number _____
Has loan been renewed, refinanced or paid off? Yes No
Dealership Name _____
New Car Used Car Year _____ Make _____

CREDITOR'S NAME AND ADDRESS

(The CREDITOR is the entity to which you make your payments)
Bank/Finance Company Name _____
Address _____
City _____ State _____ Zip _____
Phone () _____
Dealership Phone _____
Model _____

PART III A MUST BE COMPLETED BY EMPLOYER: IF SELF-EMPLOYED COMPLETE 1 Thru 7 +10 (altered answers are not acceptable)

1. Employee's Name _____
Date Hired _____
2. Occupation _____
3. Usual Number of Hours per week _____
4. Duties _____
5. Date Employee first became unable to work due to disability _____ 20 _____
Date returned to work _____ 20 _____
Reason for Employee's loss of time (check one)
 Personal Injury Laid Off
 Personal Illness Discharged
 Industrial Injury/Illness Other (Explain) _____

If industrial, please describe how injury or illness occurred _____
6. Employer's Name _____
7. Employer's Address _____
Phone () _____
8. Name of Workman's Compensation Carrier _____
9. Carrier's Address _____
10. Preparer's Signature _____
Title _____ Date _____ 20 _____

PART III B INSURED'S STATEMENT IF NOT EMPLOYED (Altered answers are not acceptable)

Have you ever received unemployment benefits?
 Yes No

Benefits Are being paid currently
 Were paid from _____ to _____

PART IV PHYSICIAN'S STATEMENT (Physician's Note: Please print or type) (Altered answers are not acceptable)

Patient's Name _____
Date of Birth ____/____/____ Height _____ Weight _____
Is condition due to pregnancy? Yes No
Beginning Date of Pregnancy _____ 20 _____

Normal Pregnancy: Yes No, Complications are _____
If she were not pregnant, would she be disabled from any other condition?
 Yes, State condition No

SPECIFIC DISABLING CONDITION

When did symptoms appear or accident happen? _____ 20 _____
Date patient ceased work due to this disability _____ 20 _____
Other conditions patient has been treated for in the past 4 years: _____

Has patient ever had same or similar condition? Yes No
If yes, when _____ 20 _____
Name and address of physician previously treating for same or similar condition _____
Name and addresses of regular physician or other physician _____

TREATMENT

Date patient first consulted you for this condition _____ 20 _____
Frequency of visits: Weekly Monthly Other, List:
When did you last examine the patient for this condition? _____ 20 _____
When is patient's next scheduled appointment? _____ 20 _____

Has patient been hospitalized for this condition? Yes No
If yes, dates of hospitalization _____ 20 _____ to _____ 20 _____
Hospital Name _____
Address _____
City _____ State _____ Zip _____

PROGNOSIS

Is patient now totally disabled from their:
REGULAR OCCUPATION? Yes No
ANY OCCUPATION? Yes No
Date total disability began _____ 20 _____
Date you released Patient to return to work _____ 20 _____
If patient has not been released, when in your opinion, may patient return to work _____ 20 _____

Signature of physician _____
Date _____ 20 _____ Specialty _____
Type/Print Physician's Name _____
Degree _____ Phone () _____
Address _____
City _____ State _____ Zip _____
Fax Number _____

ANY RESTRICTIONS? _____

THE INSURED IS RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED FOR THE COMPLETION ON THIS FORM

Protective Life Insurance Company
Claims Department
P.O. Box 790
Deerfield, IL 60015

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION FOR EVALUATION OF CLAIM

_____/_____/_____
Name of Insured or Deceased **Date of Birth** **Certificate Number**

1. Authorization and Purpose. I, _____, (circle one) **the Insured, Personal Representative of the Insured or the deceased named above**, authorize Protective Life Insurance Company (“Protective”) and its reinsurers to obtain and use information about or relating to the Insured that is relevant to evaluating a claim for benefits from a Protective policy (“Policy”) insuring the Insured. With this authorization, Protective may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical diseases and illness. With this authorization, Protective may also obtain information about mental diseases and illness including psychiatric disorders, **but any such information shall not include psychotherapy notes.**

2. Persons and Organizations Authorized to Release and Disclose Information. I authorize the following persons and organizations to release and disclose the information described in Section 1 (“Information”) to Protective or its agents acting on its behalf: (i) doctor(s); (ii) medical practitioners; (iii) pharmacists, to include Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran’s Administration, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) employers of the Insured; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the Information to a **CRA** (such as Equifax Medical Services) acting for Protective. **MIB** may not release the Information to a **CRA**.

I authorize Protective personnel who obtain or who otherwise have authorized access to the Information to release and disclose any such Information to its reinsurers, the Insured’s insurance agent or agents servicing the Policy or Policies and persons or organizations, including Protective affiliated companies, providing to Protective services related to claims administration including legal and investigative services.

3. Expiration of this Authorization. This authorization shall be valid from the date signed for the duration of a claim for the benefits of a Protective Policy. This authorization shall expire twenty-four months from the date this authorization is signed.

4. Revocation of this Authorization. I understand that I have the right to revoke this authorization by writing to **Claims Department, P.O. Box 790, Deerfield, IL 60015**. I also understand that revocation of this authorization will *not* affect any action taken in reliance on this authorization before Protective receives written notice of the revocation *nor will the revocation be effective* to the extent other law provides Protective with the right to contest a claim under the Policy or the Policy itself.

Signature and Date of Authorization

I have had full opportunity to read and consider the contents of this authorization. I understand that I may refuse to sign this authorization and that Protective does not condition payment of a claim for benefits on whether or not I sign this authorization. I further understand that pursuant to the Policy, Protective is eligible to require written proof of loss in order to process a claim under the Policy.

I understand that by signing this form I am granting to Protective the authority to obtain, use and disclose Information as described and for the purposes stated in this form. I further understand that if the persons or organizations I authorize to obtain or use the Information obtained or used through this authorization are not subject to federal health information privacy laws, they may disclose the Information, and it may no longer be protected by the federal health information privacy laws.

Signature: _____ Date: _____
(Circle One) Insured, Personal Representative or Personal Representative of the Deceased Person named above.

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.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

HIPAA (10/08)

NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia Residents: 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.

California Residents: For your protection, California law requires the following to appear on this form: 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.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware Residents: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia Residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: 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.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss of benefit is a crime punishable by fines or imprisonment, or both. A person who intentionally or knowingly violates, intentionally or knowingly permits any person over whom the person has authority to violate, or intentionally or knowingly aids any person in violating any insurance rule or statute of this State or any effective order issued by the commissioner, shall be subject to any penalty or fine as provided by this code or by the penal code of the Hawaii Revised Statutes.

Idaho Residents: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana Residents: A person who knowingly, and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana Residents: *See Arkansas.*

Maine Residents: 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 benefits.

Maryland Residents: 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 by R.S.A. 638.20.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: 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.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 Residents: *See Arkansas.*

Tennessee and Virginia Residents: 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.

Virginia Residents: *See Tennessee.*

West Virginia Residents: *See Arkansas.*

PRIVACY NOTICE

Protective Life Insurance Company, Lyndon Property Insurance Company

P.O. Box 790
Deerfield, IL 60015
1-800-445-2992

Protecting the privacy of information about our customers is important. This notice tells you how we treat information about our customers. We treat information about our former customers the same as we treat information about our current customers.

We do **not** sell information about our customers. We maintain physical, electronic and procedural safeguards to protect it. Access to customer information is limited to people who need access to do their jobs.

We get most of the information we need from customer applications and other forms. If a customer authorizes it, we may get information from others. For example, when a person applies for life insurance we may ask for permission to get information from

- Insurance support organizations such as the Medical Information Bureau and
- Consumer reporting agencies.

We also get information as we process customer transactions. The information we may have includes

INFORMATION such as

- Name,
- Address,
- Telephone Number,
- Demographic Data;

FINANCIAL INFORMATION such as

- Credit History,
- Income,
- Assets,
- Other Insurance Products;

HEALTH INFORMATION such as

- Medical history and
- Other factors affecting insurability

We use the information for business purposes, such as

- processing applications and claims,
- servicing your business, and
- offering you other products and services.

We share the information with others who provide services to help us process or administer our business. For example, we may share information with

- a company that prints our customer statements,
- medical examiners who help us underwrite life insurance applications,
- service providers who help us process claims.

We require that our service providers limit their use of the information and keep it confidential. We will not share information with anyone else unless

- we have the customer's permission, or
- we are allowed or required by law to disclose it.

You should know that your insurance sales agent is independent. The use and security of information an agent gets is his or her responsibility. Please contact your agent if you have questions about his or her privacy policy.

We have the right to change our Privacy Policy. If we make a material change to our Privacy Policy, we will notify you before we put it into effect.