Protective Life Insurance Company
Post Office Box 790
Deerfield, IL 60015
(800) 841-4777 FAX: (888) 838-8127

Thank you for contacting Protective Life Insurance Company regarding your request to file a claim. At Protective Life Insurance Company, we understand how important credit disability insurance can be in protecting your assets.

We have enclosed a claim form for credit disability insurance benefits that needs to be completed after you have met your waiting period of days as listed on your certificate. This form must be completed in its entirety and returned to us so that we can evaluate your claim.

In completing the enclosed claim form, please note what is specifically needed:

- A signed Authorization to Obtain and Disclose Information for Evaluation of a Claim.
- A copy of the retail installment contract related to the coverage and a copy of the certificate of insurance.
- PART I completed in its entirety. Please include the names, addresses and telephone numbers of all physicians, chiropractors, hospitals and pharmacies where you have been seen, treated or received medication from within the last four (4) years on the attached form. PART I must be signed, dated and completed by you.
- PART II completed in its entirety. Please make sure the loan number is correct.
- PART III completed in its entirety. This is to be completed by your employer at the time you became disabled.
- PART IV must be completed by the attending physician that is certifying to your total disability. All information in PART IV must be completed and this must be signed and dated by the physician.
- In the event there is more than one (1) loan, we will need the creditor information, a copy of the retail installment contract and a copy of the insurance certificate for each loan.

Our commitment to our certificate holders is to provide you with assistance in navigating through some of the complex paperwork that you are facing during this trying time. We ask that you contact us at 1-800-841-4777, if we may provide additional information or answer any questions you may have.

Sincerely,

Credit Insurance Claims Department
(800) 841-4777

Enclosures: Claim Form Packet & Envelope

PLEASE ATTACH A COPY OF YOUR POLICY/CERTIFICATE AND A COPY OF YOUR RETAIL INSTALLMENT CONTRACT. INCOMPLETE FORMS MAY CAUSE A DELAY IN THE PROCESSING OF YOUR CLAIM

CLAIM FORM

Reply To:
Claims Department
P. O. Box 790, Deerfield, IL 60015
Phone 1-800-841-4777 / Fax 1-888-838-8127

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

When did the accident or sickness occur? _____/_____/_____

Where and how did it happen? _____

Date you first became unable to work due to disability: _____/_____/_____

Date you returned to work:

(If not, give estimated return date) _____/_____/_____

If you have returned to work:
Date you resumed light duties: _____/_____/_____
Date you resumed regular duties: _____/_____/_____

Have you had this or a similar condition before? _____Yes _____No

Are you still physically unable to work at your usual job? _____Yes _____No

On the attached sheet please list the Name, address and phone number of all physicians and chiropractors you have consulted in the past 4 years.

Are you now or have you been receiving:

1. Worker Compensation: No ____ Yes ____
If you answered yes please complete section 1A

2. Unemployment Benefits: No ____ Yes ____
If you answered yes please complete section 2A

3. Social Security Disability: No ____ Yes ____
If you answered yes please send a copy of your award letter.

1A. If this is a Workman Compensation Claim Provide Carrier's Name _____

Address: _____

City: _____ State: _____ Zip: _____-_____ Case: _____

2A. INSURED STATEMENT REGARDING UNEMPLOYMENT IN THE LAST 5 YEARS

Have you received unemployment benefits? _____Yes _____No
Are unemployment benefits currently being paid? ___Yes ___No
List all dates unemployment benefits are being or have been paid: From: _____ To: _____ From: _____ To: _____

If Yes, please provide copies of any and all unemployment records including detailed printout(s) of all payments received.

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 Protective Life 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, retail installment contract and loan/lease contracts.**
4. **I authorize the Department of the Treasury Internal Revenue Service to provide a copy of my Tax Returns and/or a Transcript of my Tax Records and my spouse's in the event of a joint return, to the above insurance company or its authorized representatives, including, but not limited to, all attachments and/or schedules.**

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.

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.

Please Print Your Name: _____

Signature: _____

Date: _____ Drivers License Number: _____

Social Security Number: _____

Mailing Address: _____

Street Address: _____

City: _____ State _____ Zip _____

Phone: ( ) _____ Birth Date: _____/_____/_____

_____ Male _____ Female

Important:

YOUR POLICY DOES NOT PROVIDE COVERAGE FOR LATE CHARGES

1. Therefore, you should contact the office where you make your payments and arrange to make any and all payments that may come due while your claim is being processed.
2. We do not make payments in advance or without proper documentation. The creditor is paid directly for the exact number of days you are totally disabled as certified to, in writing by your physician. All benefits are subject to the provisions of your certificate and your schedule of insurance.

PART II LOAN INFORMATION

Disability Certificate Number: _____

Effective Date: ____/____/_____ Payment Date: ____/____/_____

Dealership Name: _____

Dealership Phone: ( ) _____

VIN number: _____

New Car: _____ Used Car: _____ Year: _____

Make: _____ Model: _____

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: ( ) _____

Monthly Payment: _____ Loan Number: _____

Has Loan been renewed, refinanced or paid off? _____ Yes _____ No

If Yes, please provide corresponding paperwork.

PART III EMPLOYER'S STATEMENT TO BE COMPLETED BY EMPLOYER OR YOU IF SELF EMPLOYED (Altered answers are not acceptable)

Employee's Name: _____

Date Hired: ____/____/_____

Occupation: _____

Usual number of hours worked per week: _____

Duties: _____

Date Employee first became unable to work due to disability: ____/____/_____

Date returned to work: ____/____/_____

Reason for Employee's loss of time: (check one)

_____ Personal Injury _____ Laid Off

_____ Personal Illness _____ Discharged

_____ Industrial Injury/Illness _____ Other

If industrial, please describe how injury or illness occurred:

_____

Has the Employee filed for Unemployment: No _____ Yes _____

Was Unemployment approved: No _____ Yes _____ or Denied _____

If approved when did benefits begin: ____/____/_____

Have benefits ended: No _____ Yes _____ Date: ____/____/_____

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone ( ) _____

Preparer's Signature: _____

Title: _____ Date: ____/____/_____

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: ____/____/_____

Normal Pregnancy: ____ Yes ____ No, Complications are:

_____

If she were not pregnant, would she be disabled from any other condition

_____ Yes, State condition below: _____ No

_____

SPECIFIC DISABLING DIAGNOSIS

_____

_____

_____

When did symptoms appear or accident happen? ____/____/_____

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? ____/____/_____

Name and address of physician previously treating patient for same or similar condition: _____

_____

Name and address of regular physician or other physician(s):

_____

_____

_____

TREATMENT

Date patient first consulted you for this condition: ____/____/_____

Frequency of visits: ____ Weekly ____ Monthly ____ Other, List:

_____

When did you last examine the patient for this condition? ____/____/_____

When is the patient's next scheduled appointment? ____/____/_____

Has patient been hospitalized for this condition? _____ Yes _____ No

If yes, dates of hospitalization: From ____/____/_____ To ____/____/_____

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: ____/____/_____

Date you released patient to return to work: ____/____/_____

If patient has not been released, when in your opinion, may patient return to work? ____/____/_____

Signature of physician: _____

Date: ____/____/_____ Specialty: _____

Type/Print physician's name: _____

Degree: _____ Phone:( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Fax Number:( ) _____

Complications slowing recovery: _____

ANY RESTRICTIONS? _____

_____

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

(True / False) I HAVEN'T SEEN ANY OTHER DOCTORS OTHER THAN THE ONES PREVIOUSLY LISTED ON MY CLAIM FORM.

(if you answered False, please fill out below)

FAMILY PHYSICIAN'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
DOCTOR'S FULL NAME	ADDRESS	CITY/STATE/ZIP	PHONE #
PHARMACY	ADDRESS	CITY/STATE/ZIP	PHONE #
PHARMACY	ADDRESS	CITY/STATE/ZIP	PHONE #
PHARMACY	ADDRESS	CITY/STATE/ZIP	PHONE #
HOSPITAL	ADDRESS	CITY/STATE/ZIP	PHONE #
HOSPITAL	ADDRESS	CITY/STATE/ZIP	PHONE #
HOSPITAL	ADDRESS	CITY/STATE/ZIP	PHONE #
HOSPITAL	ADDRESS	CITY/STATE/ZIP	PHONE #

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.

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."

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

PRIVACY NOTICE
Protective Life Insurance Company
2345 Waukegan Road, Suite 210
Bannockburn, Illinois 60015

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.**

HOW WE COLLECT INFORMATION ABOUT YOU
We get most of the information we need from customer applications and other forms. If a customer authorizes it, we may get information from other sources. 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

Identifying Information such as

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

Financial Information such as

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

Health Information such as

- Medical history and
- Other factors affecting insurability.

HOW WE USE THE INFORMATION WE COLLECT
We use the information for business and marketing purposes, such as

- Processing applications, claims, and transactions,
- Servicing your business, and
- Offering you additional products and services.

HOW WE SHARE INFORMATION ABOUT YOU
We share information about you with affiliates (including those listed below) and others who provide services to help us process or administer our business. For example, we may share information with others who

- Print our customer statements,
- Help us underwrite life insurance applications,
- Help us process claims, and
- Conduct surveys, analyze information, or help us market our products to you.

We require that companies limit their use of the information we share and keep it confidential. Your information will not be sold to third parties for marketing purposes.

HOW WE PROTECT YOUR PERSONAL INFORMATION We maintain physical, electronic and procedural safeguards to protect your personal information. Access to customer information is limited to people who need access to it in order to do their jobs.

ADDITIONAL INFORMATION
We will not share information with anyone else unless we have your 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.

QUESTIONS?
If you have questions about our privacy policy, please contact us at: **Protective Life Insurance Company**
2345 Waukegan Road, Suite 210
Bannockburn, Illinois 60015
1-800-323-5771

Protective Life Insurance Company
West Coast Life Insurance Company
Protective Life and Annuity Insurance Co.
ProEquities, Inc.
First Protective Insurance Group, Inc.
Lyndon Property Insurance Company
Western Diversified Services, Inc.
The Advantage Warranty Corporation
First Protection Corporation
Protective Administrative Services, Inc.
Western General Dealer Services, Inc.
First Protection Corporation of Florida
National Warranty of Florida, Inc.
Western General Warranty Corporation
Western General Warranty, Inc.
Lyndon-DFS Administrative Services Inc.
Acceleration National Service Corporation
Warranty Business Services Corporation

NOTICE

Alabama Residents – 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 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 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 knowing 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.

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: 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.

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: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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: 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.

Tennessee 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: 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.

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.