American Bankers Life Assurance Company of Florida

c/o Central Processing Services
P.O. Box 6018, Ridgeland, MS 39158-6018 • 1.800.333.5043

CONTINUING DISABILITY CLAIM FORM

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

1. **Complete Section A.**
2. **Have your Doctor complete Section B.**

- **After mailing your claim, please allow 15 business days for processing.**
- **Please include your claim number on all correspondence sent to our office.**
- **The status of your claim may be verified by calling 1-800-333-5043.**
- **New charges made to your account during a claim period are not covered and will not be paid.**
- **A claim form must be submitted with updated verification every 30 days for additional payments to be made.**

CA residents only: 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.

CO residents only: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

DC residents only: 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.

FL residents only: 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.

KY residents only: Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance 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. **HIGH LIMIT AD** - No statements made by the applicant may be changed without his written consent.

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

NM residents only: 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 civil fines and criminal penalties.

OK residents only: 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.

TX residents only: 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.

VA residents only: *This notice is not applicable to life and health insurance.

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CONTINUING DISABILITY CLAIM FORM

Please see instructions on the reverse side of this claim form.

A. CLAIMANT'S INFORMATION (must be completed for all claims) — PLEASE PRINT

NAME AND ADDRESS ☐ CHECK BOX IF THIS IS A NEW ADDRESS		CLAIM NUMBER	
		CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	
		NAME OF FINANCIAL INSTITUTION/STORE/UTILITY COMPANY (WHERE PAYMENT IS TO BE MADE)	
HAVE YOU RETURNED TO WORK SINCE YOU BECAME DISABLED ☐ Yes ☐ No If yes, ☐ Full Time ☐ Part Time		DATE RETURNED TO WORK / /	# OF HOURS PER WEEK
HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY ☐ Yes ☐ No	ARE YOU RECEIVING SOCIAL SECURITY DISABILITY ☐ Yes ☐ No	**IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR SOCIAL SECURITY AWARD LETTER OR VERIFICATION THAT YOU ARE RECEIVING SSDI.**	

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to Life Insurance Company of Mississippi. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If, in fact, the furnished information is false thereby inducing payment of claim and Life Insurance Company of Mississippi determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, Life Insurance Company of Mississippi may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false, shall give Life Insurance Company of Mississippi the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall be valid for the duration of the claim.

WARNING: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties. **For state specific Fraud Statements see page 1 of this form.**

CLAIMANT'S SIGNATURE	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	DATE
X	- -	( )	/ /

B. DOCTOR'S STATEMENT (to be furnished without expense to the Insurance Company) — PLEASE PRINT

PATIENT'S FULL NAME	DIAGNOSIS (CODE(S)) ☐ ICD-9____ ☐ CPT____ ☐ DSM III____
CURRENT DIAGNOSIS	

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)	GIVE EXACT DATES OF PARTIAL DISABILITY
FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation	FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT ☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled	IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED ☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

LAST TREATMENT DATE	NEXT VISIT	FREQUENCY OF VISITS
/ /	/ /	☐ Weekly ☐ Monthly ☐ Other ____________

DID PATIENT HAVE SURGERY SINCE LAST REPORT	IF SO, DESCRIBE SURGERY	DATE PERFORMED
☐ Yes ☐ No		/ /

HAS PATIENT PROGRESSED
☐ Yes ☐ No

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION	IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK	IF NO, DATE PATIENT WAS RELEASED
☐ Yes ☐ No	/ /	/ /

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

PHYSICIAN'S NAME (PRINT NAME)	PHYSICIAN'S SIGNATURE	MEDICAL ID #	DEGREE	DATE
	X			/ /

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER	FAX NUMBER
				( )	( )

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE

A claim form must be submitted with updated verification every 30 days for additional payments to be made.

FAILURE TO COMPLETE REQUIRED SECTIONS AND PROVIDE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.