

**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**

**AFTER 30 CONSECUTIVE DAYS OF DISABILITY**

(Example: Disabled 01/01/2009, complete form after 02/01/2009)

1. Complete Section 1.
  - a. If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
  - b. If you are self-employed, attach a copy of your business license.
2. Have your doctor complete Section 3.
3. Attach a copy of your **ENTIRE CREDIT CARD BILLING STATEMENT** (including the top portion) for the month in which your disability started.

Mail completed form and all supporting documentation to:  
DFS Claims Department  
PO Box 977122  
Miami FL 33197-7122

**ONCE YOUR CLAIM IS RECEIVED**

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

# American Bankers Life Assurance Company of Florida Time Insurance Company

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.859.0490  
Attn: DFS Claims Department

[WWW.BENEFITACTIVATIONS.COM](http://WWW.BENEFITACTIVATIONS.COM)

## DISABILITY CLAIM FORM

All benefit payments are paid directly to your creditor, and will be shown on your monthly billing statement.

### INSTRUCTIONS

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

After 30 consecutive days of disability: (Example: Disabled 1/1/09, complete form after 2/1/09)

- 1. Complete Section 1.
  - a. If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
  - b. If you are **self-employed** attach a copy of your **business license**.
- 2. Have **your doctor** complete Section 2.
- 3. **Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT (including top portion) for the month in which your disability started.**

- To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.
- If your claim is approved, a continuing claim form must be submitted every 30 days for additional payments to be made.
- After mailing your claim, please allow 15 business days for processing.

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

**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.

**MD residents only:** 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.

**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.

**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.

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

**WA residents only:** 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.

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## DISABILITY CLAIM FORM

### SECTION 1 - CARDHOLDER'S INFORMATION

PLEASE PRINT

NAME OF FINANCIAL INSTITUTION OR STORE THAT ISSUED CREDIT CARD		CREDIT CARD - ACCOUNT NUMBER	
NAME OF PRIMARY CARDHOLDER	DATE OF BIRTH / /	PLACE OF EMPLOYMENT	HOURS WORKED PER WEEK
NAME OF CLAIMANT	DATE OF BIRTH / /	PLACE OF EMPLOYMENT	HOURS WORKED PER WEEK
CLAIMANT'S JOB TITLE			DATE HIRED / /
TYPE OF EMPLOYMENT <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Self-Employed		LAST DAY YOU WORKED / /	DATE YOU RETURNED TO WORK / /
HAVE YOU RESUMED DUTIES <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		NUMBER OF HOURS PER WEEK	
ARE YOU RETIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, DATE RETIRED / /	REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT	
CLAIMANT'S STREET ADDRESS/APT. #		CITY	STATE   ZIP CODE
TELEPHONE NUMBER (DAY) (   )	TELEPHONE NUMBER (EVENING) (   )	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	

**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 the insurance company issuing my policy. 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 the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy 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 the insurance company issuing my policy the right to void my policy.

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

This authorization shall remain 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.

CLAIMANT'S SIGNATURE <b>X</b>	CLAIMANT'S SOCIAL SECURITY NUMBER - -	DATE / /
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**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.

**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.

**For other state specific Fraud Statements, see page 2 of this form.**

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

**SECTION 2 - DOCTOR'S STATEMENT**

**PLEASE PRINT**

**(to be furnished without expense to the Insurance Company)**

PATIENT'S FULL NAME		DIAGNOSIS (CODE(S)) <input type="checkbox"/> ICD-9 _____ <input type="checkbox"/> CPT _____ <input type="checkbox"/> DSM III _____			
CURRENT DIAGNOSIS					
LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS					
GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK) <input type="checkbox"/> His/Her Occupation		GIVE EXACT DATES OF PARTIAL DISABILITY <input type="checkbox"/> His/Her Occupation			
FROM / / TO / / <input type="checkbox"/> Any Occupation		FROM / / TO / / <input type="checkbox"/> Any Occupation			
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT <input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-Disabled			IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Longer than 9 months <input type="checkbox"/> Undetermined		
PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)					
<input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)					
<input type="checkbox"/> Class 2 - Medium manual activity. (15-30%)					
<input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)					
<input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)					
<input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)					
IS CONDITION DUE TO PREGNANCY <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, DESCRIBE COMPLICATIONS		ESTIMATED DATE OF DELIVERY / /	
WHEN DID SYMPTOMS FIRST APPEAR / /		WAS DISABILITY CAUSED BY AN ACCIDENT <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, DATE OF ORIGINAL ACCIDENT / /	
IF YES, DESCRIBE ACCIDENT					
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION <input type="checkbox"/> Yes <input type="checkbox"/> No		GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)			
DESCRIBE SAME OR SIMILAR CONDITION					
GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)					
DATES OF TREATMENT FIRST VISIT / / LAST VISIT / / NEXT VISIT / /				FREQUENCY OF VISITS <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____	
HAS PATIENT BEEN HOSPITALIZED <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, FROM / / THROUGH / /				NAME OF HOSPITAL	
STREET ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )
DID PATIENT HAVE SURGERY <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, DESCRIBE SURGERY		DATE PERFORMED / /	
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION <input type="checkbox"/> Yes <input type="checkbox"/> No		IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK / /		IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK / /	
PROGNOSIS/COMMENTS (HAS PATIENT PROGRESSED)					
<b>"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."</b>					
STREET ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )
ATTENDING PHYSICIAN'S NAME (PLEASE PRINT)		ATTENDING PHYSICIAN'S SIGNATURE <b>X</b>		MEDICAL ID NUMBER	DEGREE
				DATE	/ /

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

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