

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.**
If you are receiving Social Security Disability, please provide us with a copy of your award letter or verification that you are receiving SSDI.
2. **Have your employer complete Section B.**
3. **Have your doctor complete Section C.**
4. **Attach a copy of your Certificate of Insurance (including health questions) and Application for Credit Insurance if applicable.**
5. **Have Section D completed by your creditor or by the financial institution where the coverage was purchased.**
6. **If this is a revolving account, have creditor provide print out showing amount due on the date of disability.**
7. **If premiums are paid monthly, please submit a Statement of Account for the month in which disability occurred.**
8. **Complete attached Health Insurance Portability and Accountability Act (HIPAA) Authorization.**
9. **Follow your creditor's instructions for mailing the completed claim form.**

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.**

Union Security Life Insurance Company of New York

Administrative Office
P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085
Attn: DFS Claims Department

INITIAL CREDIT/CLOSED END MONTHLY OUTSTANDING BALANCE DISABILITY CLAIM FORM

All benefit payments are paid directly to your creditor.

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.)

- 1. Complete Section A.
If you are receiving Social Security Disability, please provide us with a copy of your award letter or certification that you are receiving SSDI.
- 2. Complete attached Health Insurance Portability and Accountability Act (HIPAA) Authorization.
- 3. Have your employer complete Section B.
- 4. Have your doctor complete Section C.
- 5. Have Section D completed by your creditor or by the financial institution where the coverage was purchased.
- 6. Have Creditor attach a copy of your Certificate of Insurance (including health questions) and Application for Credit Insurance if applicable.
- 7. If this is a revolving account, have creditor provide print out showing amount due on date of disability.

- 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.

A. CLAIMANT'S STATEMENT FOR ACCIDENT OR SICKNESS CLAIM **PLEASE PRINT**

NAME OF FINANCIAL INSTITUTION (WHERE PAYMENT IS TO BE MADE)				CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)	
FULL NAME OF CLAIMANT					DATE OF BIRTH / /
STREET ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE NUMBER ()
WHAT IS YOUR USUAL OCCUPATION			DESCRIBE YOUR USUAL JOB DUTIES		
WERE YOU EMPLOYED WHEN DISABILITY BEGAN <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, LAST DATE WORKED / /	GIVE EXACT REASON FOR YOUR UNEMPLOYMENT		
ARE YOU RETIRED <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, DATE RETIRED / /	REASON FOR RETIREMENT		
NAME, ADDRESS AND PHONE NUMBER OF THE EMPLOYER YOU WERE WORKING FOR WHEN YOUR DISABILITY BEGAN (IF UNEMPLOYED WHEN DISABILITY BEGAN, STATE NAME, ADDRESS AND PHONE NUMBER OF LAST EMPLOYER)					
DISABILITY CAUSED BY <input type="checkbox"/> Accident <input type="checkbox"/> Sickness		DATE ACCIDENT HAPPENED OR DATE SICKNESS BEGAN / /	DESCRIBE YOUR SICKNESS OR INJURY		
ON WHAT DATE WERE YOU FIRST TREATED BY A PHYSICIAN FOR THIS SICKNESS OR INJURY / /		GIVE NAME OF PHYSICIAN		TELEPHONE NUMBER ()	
LIST ALL DOCTORS, CLINICS, AND HOSPITALS WHICH TREATED YOU IN THE PAST FIVE YEARS, FOR ANY INJURY, ILLNESS OR GENERAL CHECK-UPS -- INCLUDE COMPLETE ADDRESS AND PHONE NUMBER (ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)					
ARE YOU NOW RECEIVING OR HAVE YOU APPLIED FOR: (IF YES, ATTACH A COPY OF THE AWARD LETTER) Social Security Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Other Disability Benefits _____					DATE OF ENTITLEMENT / /
GIVE FIRST DATE YOU DID NOT WORK BECAUSE OF THIS SICKNESS OR INJURY / /		DATE YOU RETURNED TO WORK PART-TIME / /	DATE YOU RETURNED TO WORK FULL-TIME / /	NUMBER OF HOURS PER DAY	
IF YOU HAVE RETURNED TO WORK PART-TIME, DESCRIBE THE DUTIES YOU ARE ABLE TO PERFORM					

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 as requested. 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 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.

CLAIMANT'S SIGNATURE X	SOCIAL SECURITY NUMBER - -	DATE / /
----------------------------------	-------------------------------	-------------

B. EMPLOYER'S STATEMENT **PLEASE PRINT**
(MUST BE FULLY COMPLETED)

TO BE COMPLETED BY YOUR EMPLOYER OR UNION REPRESENTATIVE					
NAME OF EMPLOYEE			DATE HIRED / /	DATE LAST WORKED PRIOR TO DISABILITY / /	
EMPLOYEE WAS ABSENT FROM JOB DUE TO <input type="checkbox"/> Accident <input type="checkbox"/> Sickness		EMPLOYEE'S OCCUPATION/JOB TITLE			
HAS EMPLOYEE RETURNED TO WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		WHAT DATE DID EMPLOYEE RESUME PARTIAL DUTIES / /	WHAT DATE DID EMPLOYEE RESUME FULL DUTIES / /		
NAME OF EMPLOYER			TELEPHONE NUMBER ()	FAX NUMBER ()	
STREET ADDRESS		CITY	STATE	ZIP CODE	
COMPLETED BY (PRINT NAME)		SIGNATURE X	DATE / /		

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

C. 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 _____

LIST THE NAMES OF ALL PRESCRIBED MEDICATIONS FOR THIS DIAGNOSIS _____

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK) His/Her Occupation **GIVE EXACT DATES OF PARTIAL DISABILITY** His/Her Occupation
 FROM / / TO / / Any Occupation FROM / / TO / / Any Occupation

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED
 Permanently Disabled Temporarily Disabled Non-Disabled 1-2 months 3 months 6 months Longer than 9 months Undetermined

PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)
 Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)
 Class 2 - Medium manual activity. (15-30%)
 Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
 Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
 Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

IS CONDITION DUE TO PREGNANCY Yes No IF YES, DESCRIBE COMPLICATIONS _____ ESTIMATED DATE OF DELIVERY / /

WHEN DID SYMPTOMS FIRST APPEAR / / WAS DISABILITY CAUSED BY AN ACCIDENT Yes No IF YES, DATE OF ORIGINAL ACCIDENT / /

IF YES, DESCRIBE ACCIDENT _____

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION Yes 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 Weekly Monthly
 Other (specify) _____

HAS PATIENT BEEN HOSPITALIZED Yes No If yes, FROM / / THROUGH / / NAME OF HOSPITAL _____

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

DID PATIENT HAVE SURGERY Yes No IF YES, DESCRIBE SURGERY _____ DATE PERFORMED / /

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION Yes 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) _____

"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."

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

ATTENDING PHYSICIAN'S NAME (PLEASE PRINT) _____ ATTENDING PHYSICIAN'S SIGNATURE **X** MEDICAL ID NUMBER _____ DEGREE _____ DATE / /

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

D. CREDITOR'S INFORMATION (ATTACH A PHOTOCOPY OF POLICY/CERTIFICATE) PLEASE PRINT

POLICY/CERTIFICATE # (INCLUDE PREFIX) _____ DATE OF ISSUE / / TERM IN MONTHS _____ AGENT CODE _____ BRANCH NO. _____ CLAIM NUMBER _____

ACCOUNT # / LOAN # _____ DUE DATE / / POLICY EXPIRES / / A&H COVERAGE Retro _____ Days Retro _____ Days FORM # OF POLICY/CERTIFICATE _____

WERE HEALTH QUESTIONS USED Yes No If yes, attach a copy of completed application.

WAS THIS LOAN REFINANCED Yes No PREVIOUS LOAN # _____ PREVIOUS POLICY # / CERTIFICATE # _____

DATE OF ISSUE / / EXPIRATION DATE / / PREVIOUS MONTHLY BENEFIT \$ _____ PREVIOUS TERM _____

MONTHLY BENEFIT \$ _____ NAME OF DEALER OR BRANCH WHERE INSURANCE WAS PURCHASED _____

FIRST BENEFICIARY/CREDITOR _____ TELEPHONE NUMBER () _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT) _____ SIGNATURE **X** DATE / /

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

Union Security Life Insurance Company of New York

Administrative Office
P.O. Box 977122, Miami, FL 33197-7122 • 1.877.438.7085
Attn: DFS Claims Department

Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following information to Union Security Life Insurance Company of New York.

INSURED INFORMATION			
NAME	SOCIAL SECURITY NUMBER - -	BIRTH DATE / /	DAYTIME TELEPHONE NUMBER ()
STREET ADDRESS		CITY	STATE ZIP CODE
MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION:			
NAME	TELEPHONE NUMBER ()		
STREET ADDRESS		CITY	STATE ZIP CODE
DESCRIPTION OF INFORMATION TO BE RELEASED			
ENTIRE MEDICAL RECORD <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER			
I UNDERSTAND THAT:			
a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization.			
b. 1. This Authorization will expire without any action by me one year after the date of my signing below. 2. This Authorization shall be valid for the duration of the claim (Arizona residents only).			
c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.			
d. This authorization is voluntary and I have the right to refuse to sign it.			
e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.			
f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.			
g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.			
h. I agree that a photocopy of this authorization shall be as valid as the original.			
i. I, or my authorized representative, have the right to receive a copy of this authorization.			
YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE) X			DATE / /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MAY BE REQUIRED)
--

ONE FORM MUST BE COMPLETED FOR EACH MEDICAL PROVIDER
Please photocopy this form if you need additional copies.