10-830 (Rev. 2/11)

Reply To:

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

CLAIM FORM

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

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 (If not, give estimated return date) _____, 20____

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."

IMPORTANT:

1. YOUR POLICY DOES NOT PROVIDE COVERAGE FOR LATE CHARGES.
   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.

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 Date_____

Dealership Name _____

Dealership Phone ( ) _____

VIN. # _____

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 A MUST BE COMPLETED BY EMPLOYER OR SELF 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 _____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

_____

Employer's Name _____

Employer's Address _____

_____ Phone ( ) _____

Name of Workman's Compensation Carrier

_____

Carrier's Address _____

_____

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 _____

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

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_____

Complications slowing recovery_____

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.

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 * Asset Protection Division

Protecting the privacy of information about our customers is important. This notice tells you how we treat information about our 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.

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 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. 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.*