

**INITIAL SINGLE PREMIUM DISABILITY CLAIM FORM**  
**Incomplete Information May Cause Delays and Inconvenience**

**STATEMENT OF LENDING INSTITUTION**

**Instructions: Type or print clearly in black ink**

ACCOUNT NUMBER	LOAN NUMBER	Certificate No. _____			
		Date Issued _____			
Payment \$ _____ ( ) Monthly ( ) Semi-Monthly ( ) Bi-Weekly	Interest Rate	Loan Due Date	Outstanding Balance \$	Date of Last Advance	Date of Last Payment
Creditor _____		By _____		Date ____/____/____	
Address _____			Phone Number _____		

**STATEMENT OF THE CLAIMANT** Instructions: Type or print clearly in black ink

1. Claimant's Name: \_\_\_\_\_
2. Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 SS# \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Home Phone: ( ) \_\_\_\_\_
3. Occupation \_\_\_\_\_ Job Duties \_\_\_\_\_
4. Are you self-employed? \_\_\_\_\_ If yes, how long \_\_\_\_\_
5. Describe the nature and details of your disability \_\_\_\_\_
6. If due to an accident, how, when and where did the accident occur \_\_\_\_\_
7. When did symptoms first appear? (Date) \_\_\_\_\_ First treated by physician for this condition (Date) \_\_\_\_\_
8. Dates you were totally disabled and prevented from performing any tasks pertaining to your occupation \_\_\_\_\_
9. Have you ever had the same or similar condition? \_\_\_\_\_ If yes, state when, describe and give names of doctor who treated you for the condition \_\_\_\_\_

10. List all doctors, including family physician and/or hospitals who have treated you for any sickness or accident in the last two years.

**(Attach another page if necessary)**

Name and address of provider	Why were you treated?	Dates of treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Are you receiving or have you received unemployment compensation? \_\_\_\_\_ If yes, give dates \_\_\_\_\_

**PAYMENTS**

**Please be advised that you remain responsible for making your monthly loan payments until your claim has been approved for payment.**

**SPECIAL NOTICE**-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.  
**FOR OHIO ONLY**-Any person who, with 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.

**AUTHORIZATION TO RELEASE MEDICAL AND EMPLOYMENT INFORMATION**

I certify that the statements contained herein are true and correct to the best of my knowledge and belief and I authorize any health care provider or any medical professional, hospital, or other medical care institution, pharmacy, government agency, insurance company, or employer to provide Oxford Life Insurance Company/North American Insurance or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf, information concerning advice, care or treatment provided to the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer to provide Oxford Life Insurance Company/North American Insurance with financial or employment related information.

I further authorize this statement to be copied and the copy utilized as if it were an original.

I understand this authorization will remain valid from the date signed for the duration of the claim.

I understand that failure to sign and date this authorization may delay the payment of my claim.

Date \_\_\_\_\_ Signed \_\_\_\_\_

**2721 N. Central Avenue, Phoenix, AZ 85004 800-585-5821 Fax 602-263-6993**

**SPECIAL NOTICE**-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.

**STATEMENT OF ATTENDING PHYSICIAN** Instructions: Type or print clearly in black ink

1. Patient's name: \_\_\_\_\_ Patient's address: \_\_\_\_\_
2. Are you this patient's regular physician? \_\_\_\_\_ How long? \_\_\_\_\_
3. If not, name and address of referring physician: \_\_\_\_\_
4. First Treatment Date \_\_\_\_\_
5. Complete diagnosis including ICD-9 \_\_\_\_\_
6. What other diseases are secondary to, complicated with, or a consequence of this condition \_\_\_\_\_
7. Has patient ever had same or similar condition? If yes, what and when \_\_\_\_\_
8. Is this condition work related? \_\_\_\_\_ If yes, explain \_\_\_\_\_
9. Is condition due to pregnancy? \_\_\_\_\_ If yes, include LMP and any complications \_\_\_\_\_
10. Was patient hospitalized? \_\_\_\_\_ If yes, include admission and discharge dates and name and address of hospital \_\_\_\_\_
11. Surgical or obstetrical procedures performed if any, including dates \_\_\_\_\_
12. Describe current course of treatment, including prognosis \_\_\_\_\_
13. Is patient still under your care? \_\_\_\_\_ Last date you saw patient: \_\_\_\_\_ Next Appointment: \_\_\_\_\_
14. Include dates of treatment for this condition during the last 2 years \_\_\_\_\_

**Total disability is defined as sickness or injury in which the insured is prevented from performing the essential duties of their occupation prior to such disability.**

15. In your opinion is, or was, the patient totally disabled as described above?  

<u>For his regular occupation</u>	<u>For any occupation</u>
Yes ( ) No ( )	Yes ( ) No ( )
16. When did total disability begin? \_\_\_\_\_ When can patient resume work? Light duty: \_\_\_\_\_ Full duty: \_\_\_\_\_
17. Dates of patients continuous total disability: \_\_\_\_\_ Dates of patient's partial disability: \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_
18. Remarks (Especially as they might help us understand patient's disability): \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Degree or Specialty \_\_\_\_\_

Print Physician's Name Here \_\_\_\_\_ Date \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Phone Number ( ) \_\_\_\_\_ Physician's Fax Number ( ) \_\_\_\_\_

**STATEMENT OF EMPLOYER** Type or print clearly in black ink

TO BE COMPLETED BY AUTHORIZED PERSON OF EMPLOYER

1. Employee name \_\_\_\_\_ Job Title \_\_\_\_\_ Hours Worked Weekly \_\_\_\_\_
2. Brief description of job duties \_\_\_\_\_
3. Dated employed \_\_\_\_\_ Date last worked prior to disability) \_\_\_\_\_ Was Employee Laid off? \_\_\_\_\_ Still Employed? \_\_\_\_\_
4. Has any other accident or sickness caused disability with in the last 12 months? \_\_\_\_\_ If yes, on what dates? \_\_\_\_\_
5. When did employee become totally disabled? \_\_\_\_\_ Will light duty work be available? If yes, what type? \_\_\_\_\_
6. When did employee return to light duty work? \_\_\_\_\_ Regular work? \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_  
Phone Number ( ) \_\_\_\_\_

To the best of my knowledge and belief all of the answers given by employee and me are true and complete.

Signed on behalf of employer by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_