

# American Bankers Life Assurance Company of Florida

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.859.0490 • Fax 305.252.6910

Attn: DFS Claims Department

## ACCOUNTGARD DISABILITY CLAIM FORM

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

### 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

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 90 CONSECUTIVE DAYS OF DISABILITY (Example: Disabled 01/01/2011, complete form after 04/01/2011)**

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

- 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.

**Fax completed form and all supporting documentation to 305.252.6910 or mail 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.

**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.

**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.

**PA residents only:** 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.

**RI 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 fines and confinement in prison.

**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.**

**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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Attn: DFS Claims Department

## ACCOUNTGARD DISABILITY CLAIM FORM

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### 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. **For state specific Fraud Statements, see page 2.**

CLAIMANT'S SIGNATURE <b>X</b>	CLAIMANT'S SOCIAL SECURITY NUMBER - -	DATE / /
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**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 FROM / / TO / / <input type="checkbox"/> Any Occupation		GIVE EXACT DATES OF PARTIAL DISABILITY <input type="checkbox"/> His/Her 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	IF YES, DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	
WHEN DID SYMPTOMS FIRST APPEAR	WAS DISABILITY CAUSED BY AN ACCIDENT	IF YES, DATE OF ORIGINAL ACCIDENT	
/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
IF YES, DESCRIBE ACCIDENT			
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION	GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)		
<input type="checkbox"/> Yes <input type="checkbox"/> No			
DESCRIBE SAME OR SIMILAR CONDITION			
GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)			
DATES OF TREATMENT		FREQUENCY OF VISITS <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
FIRST VISIT / /	LAST VISIT / /	NEXT VISIT / / <input type="checkbox"/> Other (specify) _____	
HAS PATIENT BEEN HOSPITALIZED		NAME OF HOSPITAL	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, FROM / / THROUGH / /			
STREET ADDRESS	CITY	STATE	ZIP CODE
			TELEPHONE NUMBER ( )
DID PATIENT HAVE SURGERY	IF YES, DESCRIBE SURGERY	DATE PERFORMED	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION	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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	/ /	
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 ( )
			FAX NUMBER ( )
ATTENDING PHYSICIAN'S NAME (PLEASE PRINT)	ATTENDING PHYSICIAN'S SIGNATURE	MEDICAL ID NUMBER	DEGREE
	<b>X</b>		DATE / /

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