Arkansas Bankers Life Insurance Company
3616 Jefferson Avenue • Texarkana • AR • 71854

To file a Disability Claim, please furnish the following:

••• **Completed "Disability Claim Form" (2 pages)**

Top portion for the first page should be completed by your Bank, Automobile Dealer or Creditor (Be sure your Creditor's Name, Mailing Address & Your Account Number is included)

You should complete the "Claimant's Statement" and assign payment to your creditor and sign the form

Your Attending Physician should complete the top portion of the second page

Your Employer should complete the bottom portion of the second page

(If you are self-employed, you also need to complete the "Self-Employment Questionnaire")

••• **Completed and signed "Authorization for Release of Health-Related Information, Employment Records or Other Information Needed to Determine Eligibility for Accident & Health Benefits"**

••• **Attach of copy of your insurance policy, if available**

During your continued disability, you may be required to complete additional forms at a later date. If any are needed, they will be mailed directly to you from the Claims Department at Arkansas Bankers Life.

Please return all forms and information to:
Arkansas Bankers Life Claims Department, 3616 Jefferson Ave, Texarkana AR 71854
800 451-2636 - 870 773-7221 - 870 772-7324 (Fax)

DISABILITY CLAIM FORM

Instructions to Claimant: Please have the following statements completed:
1. Claimant's Statement (you complete)
2. Attending Physician's Statement (have your doctor complete)
3. Employer's Statement (have your employer complete)
4. When completed in full, return this form to the Creditor or Agent from whom it was obtained.

CREDITOR OR AGENT'S STATEMENT *(if available) ATTACH COPY OF POLICY OF INSURANCE*

Date_____ _____ Loan or Finance Account No. _____ Original amount of indebtedness $ _____

Payable in _____ Monthly installments of $ _____ each. Present unpaid balance of indebtedness $ _____

Policy number _____

Date issued: _____ _____ Monthly benefit shown in certificate or policy $ _____ Form No. _____

Life Insurance Premium $ _____ Accident and health insurance premium $ _____

Agency (if any) _____ Address _____

Name of Dealer (if any) _____ Name of Creditor _____

Address: _____ Address: _____
(street) (city, state) (zip code) (street) (city, state) (zip code)

Completed by:_____ Phone No. _____
(area code and number)

CLAIMANT'S STATEMENT (please print clearly)

The undersigned, insured under the above numbered policy issued by Arkansas Bankers Life Insurance Company, Arkansas, represents to the company that he is now or has been totally disabled during the term of the policy and for the purpose of applying for benefits under said policy answers the following questions and represents and warrants that said answers are true, complete and correct.

1. Full Name_____ Social Security # _____
2. Mailing Address _____ Phone No. _____
(street) (city, state) (zip code) (area code & number)
3. Street Address (if different) _____ Age _____
(street) (city, state) (zip code)
4. Occupation _____ Are you self employed? _____
5. Duties performed in job _____
6. Name and complete address of employer _____
7. Attending physician _____ Complete address _____
8. Dates you were totally disabled and prevented from performing any task pertaining to your occupation?
From _____ To _____
9. Describe the nature and details of your disability _____
_____
10. When did symptoms appear or accident happen? _____
11. If accident, where? _____
12. Have you ever had the same or similar condition? YES _____ NO _____ If yes, state when and describe and give doctor's name who treated you for the condition _____
_____
13. What doctors have treated you for any sickness or accident in the last three years?

(A) Name and complete address of doctor	(B) Why were you treated?	(C) Dates you were treated

14. Are you receiving disability pension or compensation? YES _____ NO _____ For what? _____
Date of first payment _____ _____
15. Are you receiving workman's compensation? YES _____ NO _____ If yes, give dates _____
16. Are you receiving unemployment compensation? YES _____ NO _____ If yes, give dates _____

ASSIGNMENT / AUTHORIZATION

I hereby assign to _____
(Name of Creditor)

_____
(Address)

to the extent of its interest as creditor, any indemnity payable under this claim.

I further agree that Arkansas Bankers Life Insurance Company, by furnishing this blank and investigating the above claim, shall not be held to admit the validity of any claim or to waive the breach of any condition contained in the policy.

"I authorize any physician, hospital, employer, insurer or other organization or person having any records, data or information concerning me to furnish such records, data or information as may be reuqested by such company to ARKANSAS BANKERS LIFE INSURANCE COMPANY, or it's Reinsurers for the purpose of determining my eligibility for the benefits requested. I understand that in signing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original."

FRAUD 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 is guilty of a crime and may be subject to fines and confinement in prison."

Date: _____ Claimant's Signature _____

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's name and address

2. Date of birth

3. Primary diagnosis:

4. What other disease(s) are secondary to, complicated with, or a sequence of this condition:

5. Is this condition due to injury or sickness arising out of a patient's employment?
YES ( ) NO ( ) If yes, give date:

6. Is condition due to Pregnancy?
YES ( ) NO ( ) Please describe any complications:

7. (A) Nature of surgical or obstetrical procedure, if any. (describe fully):

(B) Date performed _____ ____

inpatient ( ) outpatient ( )

8. Give dates of all other medical (non surgical) treatment, if any:

Office _____

Other _____

If hospital, from _____ to _____

Name of hospital _____

Complete address _____

9. Date symptoms first appeared or accident happened:

10. Date patient first consulted you for this condition:

11. Patient ever had same or similar condition? YES ( ) NO ( )
If yes, state when and describe:
Referred by: Dr. _____ Address _____

12. Patient still under your care for this condition? YES ( ) NO ( )
If no, give date released

13. Dates patient was continuously totally disabled (unable to work):

From _____ To _____

14. Dates patient was partially disabled:

From _____ To _____

15. If still disabled, date patient should be able to return to work:

18. Date Physician's Name (print) Degree

FRAUD 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 is guilty of a crime and may be subject to fines and confinement in prison."

Physician's Signature Telephone Number (area code + number)

Street Address City State Zip Code

EMPLOYER'S STATEMENT (Not part of Physician's Statement)

Employee's Name Date Hired Name of Company

On what date did he first stop work entirely because of this sickness or injury?

On what date did he resume any part of his work, supervisory or otherwise?

(If YES, give name and address of your compensation carrier)

Was injury or disease covered under Workmen's Compensation? YES _____ NO _____

Date injury?

Date _____ _____ Signature of Employer _____
(Title)

Phone No. _____ Address _____
(Street and No.) (City, State) (Zip Code)

Arkansas Bankers Life Insurance Company
3616 Jefferson
Texarkana, AR 71854

Authorization for Release of Health-Related Information, Employment Records or Other Information Needed to Determine Eligibility for Accident & Health Benefits

This authorization complies with the HIPAA Privacy Rule

(Print Full Name, Date of Birth & Social Security # or Medical Records #)

Name	Date of Birth	SS# /Medical Record #

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Arkansas Bankers Life Insurance Company (ABL) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that ABL may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage, and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with ABL. I also authorize my employer or former employer and others to provide information about me as requested by ABL or it representative.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to ABL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that ABL has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete records, Arkansas Bankers Life Insurance Company may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

Signature of Insured/Proposed Insured or Personal Representative	Date

(Please Complete, Sign and Return to the Address Above - Keep a Copy for your Records)

Arkansas Bankers Life Insurance Company
3616 Jefferson Avenue, Texarkana AR 71854

SELF-EMPLOYMENT QUESTIONNAIRE

Name_____

Name of your business _____

Address where your business operates _____

Business telephone number_____ How long have you operated this business? _____ Are you the sole owner? _____ OR Do you have a partner? _____ If you have a partner, please give us his/her name and phone number

_____

JOB DUTIES:

Describe the work that you do:

Is lifting a part of your work? _____ If yes, how many pounds? _____ If driving is required for your business, how many hours do you drive per day? _____ per week? _____

BUSINESS OPERATION:

What date did you last work at your business? _____ Is your business able to operate without your participation? _____ Do you have employees? _____ How many full-time? _____ Part-time? _____ Was someone hired to operate the business in your absence? _____ If yes, name, address, and phone number of the person who is operating business for you _____ _____ Has your disability forced you to sell, lease, or close down your business? _____ Are you planning to return to your business? _____ Do you have documentation available, if needed, to show that you have had no income from you business since your disability began? _____ How many hours per week were you working before you became disabled? _____ If you were not working at the time you became disabled, please explain:

CURRENT ACTIVITIES:

Has your physician given an estimated date when you can return to your business? _____ Have you had surgery or is surgery planned? _____ Are you able to participate in any way in the operation of your business? _____ What work activities are you able to perform? _____

What usual work activities are you unable to perform? _____

_____

When do you anticipate returning to work part-time? _____ When do you anticipate returning to work full-time? _____

CERTIFICATION OF INFORMATION:

The above information is true and correct. If in fact the furnished information is false whereby inducing payment of claim of said insured, and Arkansas Bankers Life determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim Arkansas Bankers Life may furnish this statement to the appropriate authorities to be used in its discretion as the basis for action authorized under the law.

Signature_____ Date_____

ARKANSAS BANKERS LIFE INSURANCE CO.

3616 Jefferson Avenue
Texarkana, AR 71854

CONTINUANCE OF DISABILITY REPORT
(SUPPLEMENTAL REPORT)

Print Name _____

THE FURNISHING OF THIS BLANK IS FOR THE CONVENIENCE OF THE CLAIMANT AND IS NOT AN ACKNOWLEDGEMENT OF LIABILITY OR WAIVER OF ANY RIGHT.

CLAIM NUMBER	ACCOUNT NUMBER	DO NOT COMPLETE THIS REPORT UNTIL ➤	COMPLETION DATE	UNLESS TOTAL DISABILITY ENDS BEFORE SUCH DATE

CLAIMANT'S STATEMENT

1. DATE OF BIRTH	2. AGE	3. HEIGHT	4. WEIGHT	5. AREA CODE TELEPHONE

6. GIVE DATES PHYSICIANS HAVE TREATED YOU SINCE LAST REPORT

	OFFICE	HOSPITAL	OTHER (SPECIFY)

7. NAMES AND ADDRESS OF OTHER PHYSICIANS TREATING YOU SINCE LAST REPORT

NAME	STREET	CITY, STATE, ZIP CODE

8. WERE YOU CONFINED TO A HOSPITAL SINCE LAST REPORT? ☐ NO ☐ YES

FROM _____ HOSPITAL NAME ➤ _____

TO _____ AND ADDRESS _____

9. WHAT ARE YOUR ACTIVITIES AND HOW DO YOU SPEND YOUR TIME?

10. DESCRIBE ANY CHANGE IN YOUR CONDITION

11. HAVE YOU RESUMED WORK? ☐ NO ☐ YES

DATE RESUMED WORK

DATE EXPECTED TO RESUME WORK

12. I authorize any physician, hospital, employer, insurer or other organization or person having any records, data or information concerning me to furnish such records, data or information as may be requested by such company, ARKANSAS BANKERS LIFE INSURANCE COMPANY, or their duly authorized representative. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

FRAUD 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 is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE ☛ X

13. IF YOU LEAVE YOUR PRESENT ADDRESS TEMPORARILY OR PERMANENTLY DURING YOUR DISABILITY, PLEASE NOTIFY US

14. HAS YOUR ADDRESS CHANGED SINCE LAST REPORT?
■ NO ■ YES IF YES, USE SPACE BELOW FOR CORRECTION

CLAIMANT'S SIGNATURE _____ DATE OF REPORT _____

NAME AND ADDRESS OF CLAIMANT _____

(REVERSE SIDE IS FOR ATTENDING PHYSICIAN'S REPORT). WHEN BOTH SIDES ARE COMPLETED, PLEASE RETURN TO ABOVE ADDRESS.

ATTENDING PHYSICIAN STATEMENT
HEALTH OR ACCIDENT INSURANCE CLAIM
(SUPPLEMENTAL REPORT)

ATTENDING PHYSICIAN'S STATEMENT (REGARDING PATIENT NAMED ON REVERSE SIDE IN CLAIMANT STATEMENT)

DIAGNOSIS AND CONCURRENT CONDITIONS CAUSING TOTAL DISABILITY

2. SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY, DESCRIBE FULLY

DATE PERFORMED ☐ INPATIENT ☐ OUTPATIENT

HOSPITAL NAME

CITY, STATE, ZIP

GIVE DATES OF OTHER MEDICAL (NON-SURGICAL)

OFFICE	HOSPITAL	OTHER (SPECIFY)

4. WHAT DATE IS SCHEDULED FOR YOU TO SEE PATIENT AGAIN?
IF NONE, PLEASE EXPLAIN.

PROGRESS
☐ RECOVERED ☐ IMPROVED ☐ UNIMPROVED

6. IS PATIENT STILL UNDER YOUR CARE? ☐ YES ☐ NO

IF NO, SPECIFY DATE SERVICES TERMINATED

PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK?)
FROM TO

8. PATIENT WAS PARTIALLY DISABLED
FROM TO

9. IF STILL TOTALLY DISABLED, WHAT DATE SHOULD PATIENT BE ABLE TO RETURN TO WORK?
IF SPECIFIC DATE IS NOT KNOWN, PLEASE ESTIMATE.

FRAUD 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 is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE X

ATTENDING PHYSICIAN'S SIGNATURE DATE OF REPORT

REMARKS:

NAME OF PHYSICIAN PLEASE PRINT DEGREE

STREET ADDRESS TELEPHONE – INCLUDE AREA CODE

CITY STATE ZIP CODE