

LIFE OF THE SOUTH INSURANCE COMPANY

Administered By:

Summit Administrators, Inc.

110 West Rosamond • Houston, TX 77076-3919

Toll Free 1.800.275.3414 • Fax 713.694.0298

APPLICATION FOR DISABILITY BENEFITS

INSTRUCTIONS: A CLAIM REPORT MUST BE FULLY COMPLETED BY THE ATTENDING PHYSICIAN, EMPLOYER, AND THE INSURED AT THE END OF EACH 30-DAY PERIOD OF DISABILITY, OR WHEN THE INSURED RESUMES WORK, WHICHEVER OCCURS FIRST. RETURN THIS FULLY COMPLETED REPORT TO THE COMPANY AT THE ADDRESS ABOVE. YOUR CLAIM MAY BE DELAYED IF ALL PARTS ARE NOT FULLY COMPLETED.

PLEASE ATTACH A COPY OF THE CERTIFICATE

PART I-To be completed by the Creditor's Office

Name of Insured Debtor _____
Location or Agent No: _____ Certificate of Policy No: _____
Bank Name _____ Bank Address _____
City _____ State _____ Zip _____ Phone No _____
Customer Acct No _____ Effective Date _____
Payment Due Date ____/____/____ Term in months _____ Monthly Payment Amount \$ _____
Completed by: _____ Date ____/____/____

FOR YOUR PROTECTION, THE FOLLOWING IS REQUIRED TO APPEAR ON THIS FORM: 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, and may be subject to fines and confinement in state prison.

PART II-STATEMENT OF INSURED-To be completed and signed by Insured SS# _____

- Name _____
- Date of Birth ____/____/____ Phone(____) _____
- Address _____ City _____ State _____ Zip _____
- Name and address of employer _____ Occupation _____
- Nature of Illness _____
- Date last worked ____/____/____ Hour _____
- If illness, give date it began ____/____/____
- If accident, give date and time ____/____/____ Hour _____
- Where and how did accident occur? _____
- Have you had same or similar illness before? yes no If "yes", when? _____
- Name and address for your regular family physician and any specialty physician's.
Name of Doctor _____ Name of Doctor _____
Address _____ Address _____
Phone# _____ Phone# _____
- State dates you were totally disabled and absent from work. From ____/____/____ to ____/____/____
- State date you returned to work ____/____/____ OR date you expect to resume work? ____/____/____

I certify the foregoing statements are true and correct to the best of my knowledge and belief, without evasion or reservation.

AUTHORIZATION TO RECEIVE INFORMATION: I authorize all doctors, pharmacists, hospitals, druggists, Veterans Administration facility, or other medical related facility, institutions or persons rendering care and treatment to furnish the requesting insurance company or its representatives with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance carrier to release information for:

Name:	Date of Birth	/	/
Street Address:	City:	State:	Zip:

to LIFE OF THE SOUTH INSURANCE COMPANY and/or Summit Administrators, Inc. 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 this claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I UNDERSTAND THAT: 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. This Authorization will expire without any action by me one year after the date of my signing below. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy. This authorization is voluntary and I have the right to refuse to sign it. If I revoke this information, it will not apply to information that has already been released prior to my revocation. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history. Information released by this authorization may be subject to re-disclosure by the recipient and my not be protected any longer by the HIPAA Privacy Rule.

Claimant's Signature: _____	Date: ____/____/____
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THE INSURED IS RESPONSIBLE FOR ANY EXPENSE INCURRED FOR THE COMPLETION OF THIS FORM.

PART III-ATTENDING PHYSICIAN'S STATEMENT-To be completed and signed by Attending Physician.

NOTE TO PHYSICIAN

Since this insurance is designed to provide benefits for payments, please supply the information required on the form as soon as possible. Your prompt compliance will be greatly appreciated by both your patient and the company.

Patient's Name: _____

DIAGNOSIS:

- (a) Primary: _____
- (b) Contributory causes of disability: _____
- (c) Complications: _____
- (d) Did patient have surgery? ____yes____no If "YES", describe _____
- (e) Is disability due to pregnancy? ____yes____no Estimated date of delivery _____
- (f) If hospitalized, name & address of hospital _____

HISTORY:

- (a) When did symptoms first appear or accident happen? ____/____/____ INJURY ____yes____no ILLNESS ____yes____no
- (b) Date patient ceased work because of disability? ____/____/____ (c) Has patient ever had same or similar condition ____yes____no
- If "YES", state when and describe: _____

TREATMENT:

- (a) Initial date of treatment ____/____/____ (b) Last date of treatment ____/____/____
- (c) Frequency of visits ____weekly____monthly____other _____

EXTENT OF DISABILITY:

- (a) Give exact dates of Total Disability(unable to work) From ____/____/____ to ____/____/____
- (b) Give exact dates of Partial Disability From ____/____/____ to ____/____/____
- ____His/Her occupation____Any Occupation

PROGNOSIS:

- (a) Has patient progressed? ____yes____no (b) Progress ____improved____recovered____no change____retrogressed
- (c) Estimated date the patient can return to work ____/____/____
- (d) Is patient still under your care for this condition? ____yes____no If "NO", Patient was released ____/____/____
- (e) Any limitations? ____yes____no

NAME, ADDRESSES, AND PHONE NUMBER OF REFERRING PHYSICIAN, IF ANY: _____

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.

NAME OF ATTENDING PHYSICIAN _____ SIGNATURE _____

(please print)

Telephone(____) _____ Street Address _____ Date ____/____/____

City _____ State _____ Zip _____ Tax ID No. _____

PART IV-STATEMENT OF EMPLOYER-To be completed and signed by employer (If self-employed, so state)

1. Employee name _____
2. Was away from work beginning ____/____/____ AM ____PM through ____/____/____ AM ____PM
3. Original date of employment ____/____/____ 4. If terminated, give date ____/____/____
5. Is disability due to employment? ____yes____no If "YES", date of injury? ____/____/____
6. Description of duties _____
7. Do you describe these duties as light, medium, or heavy work? _____
8. Do you have any light duty work available? ____yes____no If "YES", as of what date? ____/____/____

By: _____

(Name of Company) _____ (Signature and Title)

Phone No: (____) _____ Date ____/____/____

(Address) _____

(City, State, Zip) _____