MINNESOTA LIFE 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#_____

1. Name_____2. Date of Birth_____/_____/_____ Phone(____)_____
3. Address_____ City_____State_____Zip_____
4. Name and address of employer_____Occupation_____
5. Nature of Illness_____6. Date last worked_____/_____/_____ Hour_____
7. If illness, give date it began_____/_____/_____ 8. If accident, give date and time_____/_____/_____ Hour_____
9. Where and how did accident occur?_____
10. Have you had same or similar illness before? ____yes ____no If "yes", when?_____
11. Name and address for your regular family physician and any specialty physician's.
    Name of Doctor_____Name of Doctor_____
    Address_____Address_____
    Phone#_____Phone#_____
12. State dates you were totally disabled and absent from work. From_____/_____/_____ to_____/_____/_____
13. 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 MINNESOTA LIFE 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:_____/_____/_____

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", Pateint 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)