



# Mountain Life Insurance Company

P.O. Box 240 • 517 Airway Drive • Alcoa, TN 37701  
(865) 970-2800 • 1-800-888-6542

## INITIAL APPLICATION FOR DISABILITY BENEFITS

### CREDITOR'S STATEMENT - MUST BE COMPLETED BY DEALERSHIP OR FINANCIAL INSTITUTION

CLAIMANT'S NAME \_\_\_\_\_ CERTIFICATE NUMBER \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_  
 MONTHLY BENEFIT \_\_\_\_\_ RETRO DAYS \_\_\_\_\_ MATURITY DATE \_\_\_\_\_  
 NAME OF DEALERSHIP \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

**\*\*WE MUST HAVE THE FOLLOWING INFORMATION TO PROCESS CLAIM PAYMENTS\*\***

FINANCIAL INSTITUTION \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_  
 MAILING ADDRESS \_\_\_\_\_ ORIGINAL LOAN AMT. \_\_\_\_\_ CURRENT BALANCE \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ ACCOUNT NUMBER \_\_\_\_\_  
 CONTACT PERSON \_\_\_\_\_ Send copies of loan documents.

### INSTRUCTIONS FOR THE CLAIMANT

1. Answer all the questions in the "Statement of Claimant." Attach a separate sheet if you need more space. Be sure to sign and date the form.
2. Your employer should answer the questions in the "Employer's Statement." If you are self-employed, you should answer the questions. If you are presently unemployed, have your last employer answer the questions.
3. Your primary physician should answer the questions in the "Attending Physician's Statement." If you are seeing more than one physician, get additional forms completed by those physicians.

### STATEMENT OF THE CLAIMANT

(MR. MRS. MS. MISS) \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

1. Describe the sickness or accident causing your disability. If injury, give date and details of accident. If sickness, give date you first noticed symptoms.

\_\_\_\_\_

2. Name all physicians from whom you received treatment during the last 12 months for any condition. Also include hospitals.

PHYSICIAN OR HOSPITAL	DATES OF TREATMENT	DESCRIBE NATURE OF DISEASE / INJURY
NAME _____ ADDRESS _____		
NAME _____ ADDRESS _____		
NAME _____ ADDRESS _____		

3. Name and address of your employer \_\_\_\_\_
4. Describe your occupation. List the duties of your job. \_\_\_\_\_
5. Date you first missed work \_\_\_\_\_ Date you returned to work \_\_\_\_\_
6. Are you receiving or have you applied for other benefits? (Include other insurance companies, unemployment compensation, social security, workers' compensation)

NAME	DATE APPLIED	BENEFITS BEGAN
_____	_____	_____
_____	_____	_____

I, the Claimant, do hereby warrant the foregoing answers to be complete and true.

I authorize any hospital, physician, surgeon, pharmacy, employer, governmental agency, insurance company, or benefit plan administrator to furnish Mountain Life Insurance Company or an agent, attorney or independent administrator acting on its behalf, information concerning advice, care of treatment provided. This authorization includes information relating to mental illness, use of drugs or use of alcohol and financial or employment-related information.

I also authorize the creditor or any transferee of the indebtedness to provide Mountain Life Insurance Company with copies of my credit application and any other information regarding the credit transaction which is the basis of the insurance.

I understand that such information will be used to evaluate my claim for insurance benefits. A photocopy of this authorization shall be considered as effective and valid as the original.

**NOTE:** 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. (In Arkansas) 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

**EMPLOYER'S STATEMENT**

COMPANY NAME \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYEE'S NAME \_\_\_\_\_ HIRE DATE \_\_\_\_\_  
JOB DESCRIPTION - (List duties, requirements and number of hours worked per week.) \_\_\_\_\_  
\_\_\_\_\_  
DATE LAST WORKED \_\_\_\_\_ REASON FOR ABSENCE \_\_\_\_\_  
IS EMPLOYEE ELIGIBLE TO RETURN TO YOUR EMPLOYMENT? \_\_\_\_\_ RETURN TO WORK DATE \_\_\_\_\_  
IS THIS A WORKERS' COMPENSATION CASE? \_\_\_\_\_  
IF SO, GIVE DATE OF INJURY AND NAME AND ADDRESS OF YOUR INSURANCE CARRIER \_\_\_\_\_  
\_\_\_\_\_  
DATE \_\_\_\_\_ BUSINESS PHONE ( \_\_\_\_\_ ) \_\_\_\_\_  
\_\_\_\_\_  
EMPLOYER'S SIGNATURE \_\_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT**

PATIENT'S NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
1. DIAGNOSIS: (a) PRIMARY CAUSE OF DISABILITY \_\_\_\_\_  
(b) CONTRIBUTING CAUSES \_\_\_\_\_  
(c) COMPLICATIONS \_\_\_\_\_  
2. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED \_\_\_\_\_  
3. IS THIS SICKNESS OR INJURY JOB RELATED? \_\_\_\_\_  
4. LIST DATES OF SERVICES - FIRST SEEN: \_\_\_\_\_  
FOLLOW-UP VISITS: \_\_\_\_\_  
IS THIS PATIENT STILL UNDER YOUR CARE? YES, NEXT APPOINTMENT DATE \_\_\_\_\_ NO \_\_\_\_\_  
5. SURGERY PERFORMED, IF ANY AND DATE \_\_\_\_\_  
6. DATE PATIENT BECAME UNABLE TO PERFORM THE DUTIES OF HIS/HER REGULAR JOB - MO. \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_  
7. DATE PATIENT CAN RETURN TO REGULAR JOB - MO. \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_; ANY JOB - MO. \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_  
8. LIST ANY RESTRICTIONS \_\_\_\_\_  
9. NAME AND ADDRESS OF THE PHYSICIAN, IF ANY, WHO REFERRED PATIENT TO YOU \_\_\_\_\_  
\_\_\_\_\_

DATE \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ DEGREE \_\_\_\_\_  
FACILITY NAME \_\_\_\_\_  
MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE ( \_\_\_\_\_ ) \_\_\_\_\_ INDIVIDUAL PRACTITIONERS - S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
FAX ( \_\_\_\_\_ ) \_\_\_\_\_ ALL OTHERS - EMPLOYER I.D. # \_\_\_\_\_



**Mountain Life Insurance Company**  
P.O. Box 240 • 517 Airway Drive • Alcoa, TN 37701  
(865) 970-2800 • 1-800-888-6542

**MOUNTAIN LIFE INSURANCE COMPANY**

**P.O. Box 240  
Alcoa, Tennessee 37701-0240  
800-888-6542**



**Medical Records Release Authorization**

**Completion of this Authorization is required in order to consider your application for our insurance or to make a determination of eligibility for benefits on your claim.**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to Mountain Life Insurance Company for the purpose of:

*Circle the purpose(s)*

- 1) **Determining eligibility for insurance;**
- 2) **Determining benefits payable on a disability claim;**
- 3) **Determining benefits payable on a life claim.**

I understand and agree that Mountain Life Insurance Company may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Mountain Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to:

Mountain Life Insurance Company  
P.O. Box 240  
Alcoa, Tennessee 37701-0240

This Authorization will expire on \_\_\_\_\_, or if no date is filled in, twelve (12) months after the date the Authorization is signed.

**A photocopy of the Authorization will be as valid as the original for the authorized purpose(s).**

<b>Signature of Individual Whose Information is to be Disclosed or Authorized Representative</b>	<b>Date of Birth</b>
--------------------------------------------------------------------------------------------------	----------------------

<b>Print Name of Individual</b>	<b>Date</b>
---------------------------------	-------------