Clear Form

Mountain Life Insurance Company
2416 Sir Barton Way Suite 110
Lexington, KY 40509
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. #_____

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Proposed Insured (Please print)	Social Security Number	Birth Date

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Mountain Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This also 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. I also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.

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 Mountain Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Mountain Life Insurance Company.

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 providing written notification to Mountain Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Mountain Life Insurance Company 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Mountain Life Insurance Company except as authorized by me or as required by law.

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 medical record, Mountain Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal data to Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

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