AMERICAN NATIONAL INSURANCE COMPANY

CREDIT INSURANCE DIVISION
P. O. BOX 696785 * SAN ANTONIO, TEXAS 78269-6785
800-899-6502

DISABILITY CLAIM FORM INSTRUCTIONS

Enclosed is a claim form required in order to process disability payments on your loan. It is important that all questions be fully answered or delay will result. To avoid late fees, continue to make your monthly payments until you receive notification that your claim has been approved. We may need to obtain your medical records. After mailing your claim form to us, please allow 10 business days for processing. All benefits will be paid directly to your creditor.

Instructions:

If the anticipated period of disability is more than 30 days, please complete the disability claim form, and submit it approximately 30 days from the first day you missed work due to disability. You should complete this form on the 30th day of the disability, regardless of the type of disability coverage purchased (7, 14, or 30 day). Payments will be made based on the date you became disabled. This may not be the same as your payment due date; therefore, we recommend that you continue with your payments to the creditor until you are notified that your claim has been approved for payment of benefits.

If the period of disability is less than 30 days, please complete the disability claim form, and submit it on the date you are released to return to work.

Your application should be completed by:

1. The Claimant (you) – Sections A and B
2. The Attending Physician – Section C
3. Your Employer – Section D

Checklist for additional information that should be submitted with your application for benefits:

_____ Copy of your insurance policy
_____ Copy of your retail installment contract. If your creditor is a credit union, please provide a copy of loan and disclosure document.
_____ Completed HIPAA authorization
_____ Completed Statement of Medical History
_____ Consent for Communication Authorization

Please note: If this is an accident, please submit a copy of the accident report. If there is no accident report, please submit a statement as to what happened and why no report was filed.

If any of the above sections are left blank, the form will be returned causing a delay in processing your paperwork for payment. Your cooperation in this matter will help speed your claim processing. All payments will be made to the creditor. Once all four sections are completed, mail your application to:

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE DIVISION
ATTN: CLAIMS DEPARTMENT
P. O. BOX 696785
SAN ANTONIO, TEXAS 78269-6785

Should you continue to remain disabled for more than 30 days, a continuation of disability form will be mailed directly to you indicating when the form should be completed and returned. The bottom portion of the continuation form will have information regarding our payment; this should be retained for your records.

If you have any additional questions, we may be reached at 1-800-899-6502. Our business hours are from 8:00 a.m. to 4:30 p.m., Central Standard Time.

FRAUD WARNINGS/STATEMENTS

Alaska
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, West Virginia
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.

California
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Delaware
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho
Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota
A person who files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

New Hampshire
Any person who with a purpose to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico
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 CIVIL FINES AND CRIMINAL PENALTIES."

Ohio, Oregon
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.

Oklahoma
"WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony."

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Tennessee, Maine, Virginia, Washington
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.

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POLICY OR
CERTIFICATE NO.

_____
(Please attach a copy)

Section A – Insured's Statement

Name _____ Telephone No. (_____) _____

Address _____ Date of Birth _____

Occupation _____ Employer _____

Cause of Disability (check one) □ Injury □ Sickness Describe Disability _____

When did this condition first appear? _____Have you had this condition before? Yes or No

Name of all physicians who have treated you for this condition:_____

_____

Date of first treatment: Month_____ Day _____ Year _____ Where _____

Name of hospital _____Address _____

Dates confined to hospital: Month_____ Day _____ Year _____ to Month_____ Day _____ Year _____

Was medical advice, consultation, or treatment required or recommended during the six month period before the effective date of your policy? (circle one) Yes or No

Was medical advice, consultation, or treatment required or recommended during the six month period after the effective date of your policy? (circle one) Yes or No

First date you were entirely away from work due to current disability Month_____ Day_____ Year _____

Date you returned to work Month _____ Day _____ Year _____

I hereby assign, transfer, and set over all my interest in the above numbered contract pertaining to this loss, and direct that my benefits payable to me under this policy be paid to the lending institution as listed on the policy, whose receipt for benefits that may be due me shall be a full acquittance of all my claims under the said contract. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
You are authorized to permit American National Insurance Company and its subsidiaries to view and obtain a copy of records pertaining to any and all medical practitioners, physicians, pharmacists, pharmacy benefit managers, hospitals, clinics, nurses, records custodians, employers, financial custodians, law enforcement agencies, or insurance companies. I understand that the information I am authorizing to be released may include:

1. AIDS/HIV test results, diagnosis, treatment, and related information
2. Drug screen results and information about drug or alcohol use and treatment
3. Mental health information
4. Pharmacy prescriptions

I further understand that this authorization is valid for one year from the date executed below. I also understand that I may revoke this authorization at any time during the one year period by notifying the Claims Department in writing at the address shown at the top of this form. The information obtained by this authorization will be used to evaluate this claim. The information obtained by this authorization may be disclosed to reinsurance companies, if policy is reinsured, to any agency employed by the Company, and to any party, which the Company is required by law or subpoena to disclose. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company and may no longer be protected by the same rule that applied in the first instance.

Date _____ **Claimant** _____
Signature

(over)

AMERICAN NATIONAL

Section B – Creditor Information

Loan No._____ Name of Debtor _____ Social Security No. _____ Age __

Effective Date of Loan _____ Termination Date _____ Term of Loan (months) _____

Initial Amount of Loan $_____ Monthly Payment Amount $_____ Name of Creditor_____

Address_____Branch No._____Telephone No. _____

Section C – Statement of Attending Physician

Patient's Name _____ Address _____

Is condition due to pregnancy? Yes or No If yes, describe the complications _____

Diagnosis – Please mention any complications _____

_____

Please advise of history pertinent to the CAUSE of this disability _____

_____

When did this patient first consult you about this condition? _____

When did symptoms first appear according to the patient? _____

What diagnostic and/or surgical procedures were performed? _____

What treatment was prescribed? _____

Date patient was confined to a hospital: From_____To _____

Name of hospital _____ Address _____

Dates of treatment you have provided the patient in the past 60 days _____

In your opinion, when did the patient become totally disabled? Month _____ Day _____ Year_____

In your opinion, when can or did the patient resume any work? Month _____ Day _____ Year _____

Name of other attending physicians _____

_____ _____ _____

Physician's Full Name (Please Print) **Physician's Signature** **Date**

_____ _____

Address, City, State, Zip **Telephone No.**

Section D – Statement of Employer

Our employee, _____, whose original hire date was _____, was disabled from work beginning _____ and did not return to work until _____.

Employer _____ Address _____ Telephone No._____

_____ _____ _____

Employer's Signature **Title** **Date**

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Statement of Medical History

Insured: _____ Claim No._____

Please provide the names, addresses, telephone numbers, and dates of service for all of the physicians, hospitals, and pharmacies, which provided treatment for the Insured. Please use the reverse side of this form for additional names.

PRIMARY CARE PHYSICIAN:

Name _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

Dates of Service (From) _____ (To) _____

OTHER PHYSICIANS and/or HOSPITALS:

Name _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

Dates of Service (From) _____ (To) _____

Name _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

Dates of Service (From) _____ (To) _____

Statement of Medical History - Continued

PHARMACY: _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

PHARMACY: _____ Address _____
(Street)

Phone No. ( ) _____ _____
(City, State, Zip)

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AUTHORIZATION
This authorization is designed to comply with the HIPAA Privacy Rule

TO THE INSURED: During your claim and as a part of the claim proof requirements of your policy, Servco Life Insurance Company, and its administrator, American National Insurance Company (the Company), will need information to determine your eligibility for benefits. All information we obtain with this Authorization will be kept confidential. Please immediately complete, sign, date, and return this Authorization to help us promptly consider your claim. Any alteration to or limitation of this Authorization will prejudice the Company's right to independently evaluate your claim and may prevent benefits from being provided.

I AUTHORIZE THESE PERSONS OR ENTITIES having any knowledge of my health or me:
Physician, therapist, healer, or medical practitioner, hospital, clinic, pharmacy, or other medically related facility or association * other health care provider * insurance company or insurance support organization * employer, business associate, group health plan, or administrator * law enforcement agency * Social Security Administration * agency, organization, or entity administering a benefits program * educational, vocational, or rehabilitation organization, financial institution, bank, accountant, tax preparer, attorney, or * other persons or institutions.

TO PROVIDE THE FOLLOWING INFORMATION TO COMPANY or its authorized representatives: my complete patient file and entire medical record including any charts, notes, x-rays, operative reports, lab, and medication records, copies of all prescriptions, and all other medical information about me including my medical history, diagnosis, testing, and test results, consultation reports, prognosis, and treatment of any physical condition, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes, communicable disease or disorders, sexually transmitted disease, mental, psychiatric, or psychological condition including test results, drug, alcohol, or other substance abuse including treatment or therapy.

- Non-medical information about me, including information concerning my education, occupation, employment history, earnings, finances, unemployment benefits, applications for insurance, or eligibility for other benefits
- Social Security information concerning me, including detailed information regarding earnings for up to ten years, and/or a summary record of total earnings, and/or information from master benefits records regarding the award, denial, or continuation of benefits.

I UNDERSTAND, ACKNOWLEDGE, AND AGREE to the following provisions:
No Restrictions: Any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct the persons or organizations identified in paragraph two (2) above to release and disclose my entire medical record without restriction. **Purpose**: The Company will use the information to (1) properly evaluate my claim and determine my eligibility for coverage; and (2) conduct other legally permissible activities. **Use**: In the course of conducting its business, the Company may disclose to other parties information about me. The Company may release this information about me to affiliates, reinsurers, and any person performing business or legal services for the Company. The information disclosed pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule and may be redisclosed pursuant to this Authorization or otherwise as permitted or required by law. **Right to Revoke**: I have the right to revoke this Authorization at any time by sending a written statement to Company, Credit Insurance Division at P.O. Box 696785, San Antonio, Texas 78269, except to the extent it has been relied upon to disclose requested records. **Expiration**: This authorization will remain in effect for a maximum of 12 months from the date of signature below. **Copy**: My authorized representative or I have a right to receive a copy of this Authorization. A photocopy or facsimile of this authorization is as valid as the original. I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process benefit payments requested under my policy.

I understand any false statement made knowingly and willfully to obtain information from federal records is punishable by fine, imprisonment, or both.

SIGNATURE OF INSURED OR PERSONAL REPRESENTATIVE	DATE	IF REPRESENTATIVE, GIVE RELATIONSHIP

PRINT NAME OF INSURED	DATE OF BIRTH	SOCIAL SECURITY NUMBER

POLICY/CERTIFICATE NUMBER

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CONSENT FOR COMMUNICATION

Pursuant to the Graham-Leach-Bliley Act, American National Insurance Company must adhere to certain guidelines in handling credit insurance claims. Please read each paragraph and initial that you understand and give consent for the following:

I, _____, understand that I have filed a credit disability claim

( ) and hereby authorize any physician, hospital, government agency, insurance company, workers' compensation carrier or organization to release to American National Insurance Company information regarding my medical history/treatment and any past or present employment status.

( ) and hereby authorize my creditor, _____, to speak with American National Insurance Company regarding my loan account.

Please initial the spaces ( ) by each paragraph that you have read and understand each consent. Print your name, the name of your creditor, and the name of your representative in the spaces provided.

_____ _____
Please sign your name Date

This form shall remain valid through the life of the claim.