SOUTHERN PIONEER LIFE INSURANCE COMPANY
PO BOX 64270, ST. PAUL, MN 55164-0270
PHONE 1-800-482-9260 FAX 1-800-604-7819

DISABILITY CLAIM FORM

***CREDITOR*: COMPLETE THIS SECTION**

NAME OF INSURED**:** _____

LOAN ACCOUNT #:_____ EFFECTIVE DATE OF LOAN: _____ ORIGINAL LOAN AMOUNT: $_____

☐ HOME EQUITY ☐ OPEN END ☐ CLOSED END ☐ APR _____**%** ☐ FIXED ☐ VARIABLE

☐ SINGLE PREMIUM/CERTIFICATE #:_____ MONTHLYPAYMENT: $_____

NAME OF CREDITOR: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REPRESENTATIVE SIGNATURE: _____DATE: _____TELEPHONE (___) _____
(Please Print Name of Representative)_____

***STATEMENT OF CLAIMANT*: COMPLETE IN FULL**

1. FULL NAME **(please print):**_____

2. STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____

3. TELEPHONE :( )_____ BIRTH DATE: _____ AGE: _____ SEX: _____ WEIGHT: _____ HEIGHT: _____

4. CURRENT EMPLOYER: _____ POSITION/JOB TITLE: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER ( ) _____ FAX NUMBER ( ) _____

5. EXACT DAY LAST WORKED: MONTH_____ DAY_____ YEAR_____ A.M._____ P.M._____

6. EMPLOYER (AT TIME LOAN WAS TAKEN OUT) _____

ADDRESS OF HUMAN RESOURCES: _____ CITY: _____STATE:_____ZIP:_____
TELEPHONE NUMBER (____) _____ FAX NUMBER (_____) _____

7. DESCRIBE EXACT NATURE OF ILLNESS, INJURY OR ACCIDENT: _____
_____

HAVE YOU EVER HAD THE SAME/SIMILAR KIND OF ILLNESS/INJURY BEFORE? YES ☐ NO ☐
IF YES, WHEN? MO.: _____ DAY: _____ YEAR: _____ NAME OF PHYSICIAN TREATING_____

8. IF ACCIDENT, DATE OF ACCIDENT: _____
WAS THIS COVERED BY WORKER'S COMPENSATION? IF SO, CASE # _____
PLACE OF ACCIDENT: _____ DATE: _____ APPROX. TIME: _____
HOW DID IT HAPPEN? _____

9. PHYSICIAN(S) TREATING YOU FOR THIS CONDITION: _____ TELEPHONE: (____) _____
MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
(If more than one please attach a list including physician's name, address and telephone)

10. FAMILY PHYSICIAN: _____ TELEPHONE: _____
MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

11. DATES OF TOTAL DISABILITY: FROM: _____ TO: _____ **(UNABLE TO DO ANY WORK)**

12. HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO DATE: _____ LIGHT DUTY? ☐ YES ☐ NO

13. IF HOSPITALIZED, GIVE NAME/ADDRESS OF HOSPITAL AND DATES YOU WERE CONFINED: _____
_____

I hereby authorize any employer, hospital, physician, or other person, to furnish to Southern Pioneer Life Insurance Company, any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and any and all information with respect to employment and/or employment history. A photocopy of this authorization shall be considered as effective and valid as the original. I know that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization shall remain valid for the duration of my claim.

INSURED SIGNATURE: _____**DATE:**_____
(Please sign in ink)

NOTICE: 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.

ATTENDING PHYSICIAN COMPLETE THIS SECTION *(Please Print)*

(The patient is responsible for the completion of this form without expense to the company)

PATIENT'S FULL NAME: _____ **DATE OF BIRTH:** _____

1. **DIAGNOSIS/CONDITION CAUSING PRESENT DISABILITY**: _____

INCLUDE ICD-9 CODE(S) _____

Date symptoms first appeared: _____

Date patient first consulted: _____

Date accident happened: _____ **Place:** _____

Date first placed on disability by you: _____

Describe nature of accident and injuries: _____

_____

2. IS THIS A REGULAR PATIENT OF YOURS? ☐ YES ☐ NO **3**. WAS THIS PATIENT REFERRED TO YOU? ☐ YES ☐ NO

IF YES, WHEN: MO. _____ DAY _____ YEAR: _____

IF YES: NAME OF REFERRING PHYSICIAN: _____TELEPHONE (____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

4. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

5. IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO

ESTIMATED DELIVERY DATE: _____ VAGINAL OR C-SECTION **(circle one)**

6. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐YES ☐ NO

IF YES: DATE(S): _____ **TREATMENT**: _____

7. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION: _____

_____

8. WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO _____ INPATIENT _____ OUTPATIENT _____ ER

IF YES: DATE(S): FROM: _____ THRU: _____ NAME OF HOSPITAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

9. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY, DESCRIBE FULLY: _____

_____

DATE PERFORMED: _____

10. GIVE DATES OF ALL OTHER MEDICAL TREATMENT, ADVICE OR CONSULTATION PROVIDED GIVEN FOR THE PRIMARY DIAGNOSIS LISTED ABOVE DURING THE PAST TWO YEARS: _____

_____

11. LIST ALL MEDICATIONS/DOSAGES PRESCRIBED FOR PATIENT: INCLUDING THE PRIMARY DIAGNOSIS

1. MEDICATION: _____
2. FREQUENCY: _____
3. DOSAGE: _____

12. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

When will patient be seen again? _____If no, give date of release: _____

13. HAS PATIENT BEEN REFERRED TO ANOTHER PHYSICIAN? ☐ YES ☐ NO

IF YES, PHYSICIAN'S NAME/ADDRESS/TELEPHONE NUMBER: _____

_____

14. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED **(unable to work):**

FROM: MO. _____ DAY _____ YEAR _____ **THRU:** MO. _____ DAY _____ YEAR _____

15. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED FROM WORK: **(Need Actual Date)**

FROM: MO. _____ DAY _____ YEAR _____ **THRU:** MO. _____ DAY _____ YEAR _____

_____ _____ _____

SIGNATURE (ATTENDING PHYSICIAN) **DEGREE** **DATE**

_____ _____ (_____)_____

PRINT OR TYPE PHYSICIAN'S NAME **TAX ID #** **TELEPHONE**

_____ _____ _____ _____ _____

ADDRESS **CITY** **STATE** **ZIP CODE** **FAX NUMBER**