Disability Claim Form

Please complete pages 1 and 2 and return to us.

Contact Us:
PO Box 584
Marksville, LA 71351-0584
318-240-8696

Section One - Personal Information - Completed By You

Your first name and middle initial		Last Name	
Street address		Apt. no.	City, state and zip code
Birth Date	Last 4 digits of your Social Security #	Phone number (include area code) ( ) -	

Section Two - Disability Information - Completed By You

Cause of disability	Dates you have been unable to work due to your disability
Name of attending physician (physician currently treating you), their clinic name and phone number	
Name of personal physician (provider of most of your medical care), their clinic name and phone number	
Are you currently working for wages? Yes ☐ No ☐	Date that you either did return to work or expect to return to work
If this is your first claim form for this disability, have you ever received treatment for this condition prior to this disability? Yes ☐ No ☐	If yes, please provide the date of first treatment prior to this disability

Section Three - Employment and Income Information - Completed By You

Your occupation at the time of your disability	Annual Income	Are you self employed? Yes ☐ No ☐	Date last worked?
Employer's name at the time of your disability		Disability benefits you are receiving SSDI ☐ WC ☐ None ☐	Employer phone number ( ) -

Section Four - Certification and Signature - Completed By You

By signing below, I certify that: (1) the above statements are complete and accurate to the best of my knowledge (2) I was given a copy of Eagle American Life Insurance Company's "Information Notice" document (3) I agree to allow the Company to procure an Investigative Consumer Report about me, if necessary.

Your signature **X** Date signed **X**

Section Five - Attending Physician's Statement - Completed By Physician

Note: We do not accept physician work release slips unless authorized by us. Patient is responsible for any physician charges for completing forms.

Cause of disability (please use medical terminology)		ICD #	Contributing factors to disability
Date of first treatment for this disability	Has the patient ever been treated for the same or similar condition prior to this disability? Yes ☐ No ☐		If yes, please provide date(s)
Date surgery scheduled (if recommended)	Date surgery perfomed (if done)	Date patient last treated	If cause of disability is complications of pregnancy, please list due date
Have you recommended the patient not work? Yes ☐ No ☐	If yes, until what date?	Anticipated/ actual date released to work with no restrictions	
Is the patient allowed to work with restrictions? Yes ☐ No ☐	If yes, please provide a brief list of restrictions		
Name, address and phone number of physician medical facility			
Physician signature **X**		Date signed **X**	

Any person who knowingly and with intent to defraud, files a statement of claim containing any materially false or misleading information, commits a fraudulent act which is a crime.

Authorization To Collect And Disclose Information

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Section Six - Authorization To Collect And Disclose Information- Completed By You

I understand Eagle American Life, its reinsurers, and all persons or companies authorized to represent these parties may obtain **Information** (described below) about me as allowed or required by law from a **Source** (described below) in order to evaluate my claim for disability benefits with Eagle American Life Insurance Company. I authorize any Source(s) to disclose or release Information to Eagle American Life Insurance Company, P.O. Box 584, Marksville, LA 71351-0584 or its authorized representative when this Authorization is presented.

Information is defined as facts about me. It includes facts about these topics; mental and physical health, including facts about communicable or sexually transmitted diseases such as HIV infection, AIDS, Hepatitis and Syphilis; prescription drug records; tobacco, drug and alcohol use; other insurance coverage; employment; character; general reputation; mode of living; finances; vocation; and other personal traits. **It does not include facts about sexual orientation or psychotherapy notes.**

Source is defined as medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; insurers; reinsurers; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

I Acknowledge That:

The purpose for the release of Information is to allow Eagle American Life Insurance Company to make a claims decision regarding payment of possible disability insurance claim benefits and/ or to resolve any issues of incorrect or misrepresented information that may have originally been provided on an application for insurance with Eagle American Life Insurance Company.

I understand that any Information disclosed pursuant to this Authorization may no longer be covered by federal rules concerning privacy and confidentiality of personal information, but it will not be redisclosed by the recipient except as authorized by me or as allowed by law. Consumer Reporting Agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information.

Any agreements that I may have made to restrict my Information do not apply to this Authorization and I instruct any Source to release and disclose the entire contents contained in my Information file to Eagle American Life Insurance Company without restrictions and to the limits allowed by law. Information may be transmitted via U.S. regular mail, various other land or air mail services and through the use of secured electronic devices.

This Authorization will remain in effect for 12 months from the date it is signed by me and that a copy is as valid as the original and that I am entitled to a copy of this Authorization upon request. I further understand I may revoke this Authorization by sending a written request to Eagle American Life Insurance Company at the address listed above and that it will become effective when received by them. Any action already taken in reliance on this Authorization cannot be reversed and my revocation will not affect those actions.

I understand that a medical provider to whom this Authorization is submitted may not condition its treatment of me on whether or not I sign this Authorization. I further understand that if I refuse to sign this Authorization, Eagle American Life Insurance Company may not be able to make disability insurance benefit payments.

I may request and receive a copy of the Information described on this form by submitting a written request to Eagle American Life Insurance Company at the address listed above.

I have been given Eagle American Life Insurance Company's **Information Notice** document.

☐ I elect to be interviewed if any investigative consumer report is prepared in connection with my claim for benefits.

Claimant or Personal Representative signature (required)	Relationship to Claimant (required)	Date signed (required)
X	X	X

Printed name of person signing (required)	Claimant date of birth (required)	Claimant Social Security Number (required)
X	X	X

Information Notice

This document is for your information.
Please do not submit with pages 1 and 2

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Section Seven - Information Notice - To Be Read And Kept By You

Our Commitment to You

Eagle American will act as quickly, fairly and compassionately as possible on your claim for disability benefits. We know that loss of time from work due to a disability is stressful. To assist us in doing this, please be sure that the claim form is properly and completely filled out before submitting it to us. Wrong information or no information on the claim form will cause us to send it back to you for corrections.

Your Claim Responsibilities

You must provide us with truthful, accurate and timely claim forms and any other reasonably necessary information or documents that will assist us in processing your claim accurately. Claim forms may be sent to you no more frequently than monthly. Please be advised that you may be violating state law if you knowingly conceal material facts or submit a claim form that contains materially false information. You have the right to decline to provide Eagle American with the requested information or documents, but Eagle American has the right to discontinue processing of your claim if you choose to deny us access to information that is reasonable and necessary to process your claim.

Processing Time, Payment of Claims and Your Loan Responsibilities

If this is your initial claim for disability benefits, please allow up to four weeks for processing time. If this is a continuing claim, please allow up to two weeks for processing time. You should continue to make loan payments until you hear from us. Payment of claims is made directly to your financial institution unless your loan has been fully repaid or your financial institution directs us to do so.

It is your responsibility to keep your loan payments current and pay any late fees, if they are assessed. Insurance is designed to repay your loan if you are disabled, but we make no guarantees to keep your loan current due to processing restrictions. Also, disability insurance is typically paid for PAST time off work and this means our payments most likely will be received AFTER your loan payment is due. To avoid late fees on loans, please continue to make your loan payments until you receive information from us indicating that we have sent payment to your financial institution.

Contestability of Coverage and Pre-Existing Conditions

Because your original application for insurance was most likely our primary source of information in accepting your application, we may conduct a review of the accuracy of your answers on this application when you submit your initial claim form to us (if you file within two years after taking coverage out). If, upon review, materially incorrect information is found on your application, your claim may be denied and your coverage may be considered void as of the Effective Date. In this situation, we will refund 100% of your premium and provide you with a complete description of what information we relied upon in making our decision. Also, we may verify whether or not your disability is a result of a medical condition that fell within the pre-existing period contained in your insurance policy or certificate. If your disability is a result of a pre-existing condition, we may not make payment on your claim. Please read the “Exceptions” or “Exclusions” area of your policy or certificate for more information.

Our Information Practices

We will rely primarily on information provided by you and your physician(s). On occasion, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report (please check the appropriate box at the bottom of page 2). In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate. We will send you a more detailed explanation of our information practices if you send us a written request to the address listed above.

Federal Fair Credit Reporting Act

This notice is provided to you in compliance with 15 USC 1681 et. seq. As part of our claims processing, we may ask that an investigative consumer report be prepared. A consumer reporting agency will prepare this report. The report may typically include information as to your character, general reputation, mode of living and personal characteristics. “Mode of living” does not include information related directly or indirectly to your sexual orientation. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the investigation. If you would like to inspect and receive a copy of the report, you may do so by contacting the agency directly.