DISABILITY CLAIM FORM

Merit Life® INSURANCE CO.
A Stock Company Domiciled in Indiana

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Complete **SECTION 1**
2. Read, sign and date **SECTION 2**
3. Print your name and your account number in **SECTION 3**
4. The physician who can verify your disability must complete **SECTION 4**
5. Read, sign and date **SECTION 5**
6. Send **BOTH PAGES** of the completed, signed claim form and any attachments to Merit Life Insurance Claims Department. Keep a copy for your records.

If you need assistance with this form, contact Merit Life Insurance Co. at 1-800-325-2147, ext 5113293, or your lender.

SECTION 1 TO BE COMPLETED BY CLAIMANT (PLEASE PRINT)

ACCOUNT #	CHECK ONE	NEW CLAIM ☐	CONTINUING CLAIM ☐
CUSTOMER NAME			
MAILING ADDRESS		IS THIS A NEW ADDRESS? YES ☐	NO ☐
CITY, STATE, ZIP			
DAYTIME PHONE # ( )	DATE OF BIRTH	LAST 4 DIGITS OF SS #	
ARE YOU RECEIVING SOCIAL SECURITY DISABILITY YES ☐ NO ☐	EMAIL ADDRESS (OPTIONAL)		
NAME OF EMPLOYER	STREET ADDRESS		
CITY	STATE	ZIP	
EMPLOYER'S PHONE # ( )	EMPLOYER'S FAX # ( )		
OCCUPATION			
DATE LAST WORKED	BEGINNING DATE OF DISABILITY		
DESCRIBE ILLNESS OR INJURY			
HAVE YOU RETURNED TO WORK YES ☐ NO ☐	IF YES: FULL DUTY ☐	LIGHT DUTY ☐	RETURN DATE
HAVE YOU HAD THE SAME OR SIMILAR ILLNESS BEFORE YES ☐ NO ☐	IF YES, PLEASE PROVIDE THE DATE(S)		
COMMENTS			

SECTION 2 AUTHORIZATION TO RELEASE INFORMATION

By signing below, I authorize the release and disclosure of any of my information; including but not limited to: personal information, diagnosis(es), medical condition(s) and any reports that will aid the Insurance Company with its investigation of my claim with any party. I authorize any physician, hospital, medical or medically related facility or any other individual or facility where I have been treated, examined, admitted, or confined to release information concerning my medical history, mental or physical condition(s), or treatment which may be requested by the Insurance Company or its duly authorized representative for the purpose of determining my eligibility for the benefits I have requested. I authorize any employer, insurer, or other individual or organization, including but not limited to: Social Security Administration or Railroad Retirement Board, having any records, files, reports, etc., concerning me to release the information to the Insurance Company or its duly authorized representative for the purpose of determining my eligibility for the benefits I have requested. This authorization shall remain valid for the term of coverage of the policy. However, I have the right to revoke this authorization in writing within one year from the date of my signature. A photocopy of this authorization shall be valid as the original and I or my authorized representative shall receive a copy of this authorization.

CLAIMANT SIGNATURE: _____ **DATE:** _____

SECTION 3 TO BE COMPLETED BY CLAIMANT (PLEASE PRINT)

CLAIMANT NAME _____ **ACCOUNT#** _____

SECTION 4 TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT) (completed without expense to Merit Life)

PATIENT'S NAME FIRST		MI	LAST
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED		DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	
DIAGNOSIS(ES) / COMPLICATIONS			ICD CODE(S)
ALL DATES OF TREATMENT			
NAME AND ADDRESS OF PHYSICIAN(S) WHO **PREVIOUSLY** TREATED PATIENT FOR THE ABOVE CONDITION			
IF HOSPITALIZED, PLEASE PROVIDE DATES	FROM		TO
NAME OF HOSPITAL		CITY	STATE
NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE		IF PREGNANCY, DATE OF DELIVERY	
CHECK IF PATIENT IS **TOTALLY** DISABLED ☐ **PARTIALLY** DISABLED ☐		BEGINNING DATE OF DISABILITY	THROUGH
PHYSICIAN'S PHONE # ( )		PHYSICIAN'S FAX # ( )	
PHYSICIAN'S EMAIL ADDRESS			
PHYSICIAN'S PRINTED NAME FIRST		MI	LAST

PHYSICIAN'S SIGNATURE _____ DEGREE _____ TODAY'S DATE _____

SECTION 5 INSURANCE FRAUD WARNING

For your protection California law requires the following to appear on this form: 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.

CLAIM PROCEDURE

Send in the completed form to the insurance company as soon as possible and tell your creditor as soon as you do. (Your creditor has already advised you of the address or telephone number to use to confirm that you have submitted your completed form to the insurance company).

If your disability insurance covers all of your missed payments, YOUR CREDITOR CANNOT TRY TO COLLECT WHAT YOU OWE OR FORECLOSE UPON OR REPOSSESS ANY COLLATERAL UNTIL THREE CALENDAR MONTHS AFTER your first missed payment is due or until the insurance company pays or rejects your claim, whichever comes first. Your creditor can, however, try to collect, foreclose, or repossess if you have money due and owing or are otherwise in default when your disability claim is made or if a senior mortgage or lienholder is foreclosing.

If the insurance company pays the claim within the three calendar months, your creditor must accept the money as if you paid on time. If the insurance company rejects the claim within the three calendar months or accepts the claim within the three calendar months as a partial disability and pays less than for a total disability, you will have 35 days from the date that the rejection or the acceptance of the partial disability claim was sent to pay past due payments, or the difference between past due payments and what the insurance company pays for the partial disability, plus late charges. You can contact your creditor who will tell you how much you owe. After that time, your creditor can take action to collect or foreclose or repossess any collateral you may have given.

If the insurance company accepts your claim, but requires that you send in additional forms to remain eligible for continued payments, you should send in these completed additional forms no later than required. If you do not send in these forms on time the insurance company may stop paying, and your creditor will then be able to take action to collect or foreclose or repossess any collateral you have given.

I HAVE READ AND UNDERSTAND THE INFORMATION ON BOTH PAGES OF THIS FORM. I AFFIRM THE INFORMATION I PROVIDED HEREIN IS ACCURATE AND COMPLETE.

CLAIMANT SIGNATURE: _____ **DATE:** _____

MAIL TO: **MERIT LIFE INSURANCE CO.**
601 N.W. SECOND STREET, P.O. BOX 39
EVANSVILLE, IN 47701-0039

OR FAX TO: **1-800-350-9582**

OR EMAIL TO: **InsClaims@onemainfinancial.com**