

PLATEAU INSURANCE COMPANY

P.O. BOX 7001 CROSSVILLE, TENNESSEE 38557-7001 PHONE # 800-752-8328

ADMINISTRATOR FOR: GUARANTEE TRUST LIFE INSURANCE COMPANY - INDIVIDUAL ASSURANCE COMPANY
 KENTUCKY HOME LIFE INSURANCE COMPANY - INVESTORS HERITAGE LIFE INSURANCE COMPANY
 MINNESOTA LIFE INSURANCE COMPANY- A SECURIAN COMPANY

CLAIMS DEPARTMENT FAX NO: (931) 459-3113

EMAIL: PLATEAU.CLAIMS@800PLATEAU.COM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

TO BE FURNISHED WITHOUT EXPENSE TO THE INSURANCE COMPANY

1. PATIENT'S FULL NAME _____ AGE _____
2. ADDRESS _____
- STREET CITY STATE ZIP

***** THE PURPOSE OF THIS FORM IS TO CERTIFY YOUR PATIENT'S DISABILITY AND TIME OFF WORK

DIAGNOSIS	3. DIAGNOSIS CAUSING DISABILITY (Describe any complications)	
	4. DATE SYMPTOMS FIRST APPEARED OR INJURY OCCURRED	DATE: _____
	5. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	DATE: _____ Was the insured a new patient on that date? YES <input type="checkbox"/> NO <input type="checkbox"/>
	6. WHO REFERRED PATIENT TO YOU? WHO IS INSURED'S PRIMARY CARE PHYSICIAN?	
	7. IS CONDITION DUE TO NORMAL PREGNANCY? YES _____ NO _____	ARE THERE PREGNANCY COMPLICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO ESTIMATED DELIVERY DATE: _____
PHYSICIAN'S TREATMENTS	8. DATES YOU TREATED PATIENT FOR THIS CONDITION: (* if too numerous, please attach an itemized bill)	DATES: _____
	9. IF HOSPITALIZED, GIVE DATE, NAME, AND ADDRESS OF HOSPITAL:	ADMITTED: _____ DISCHARGED: _____ HOSPITAL: _____ SURGERY DATE: _____ PROCEDURE: _____
	10. NEXT APPOINTMENT DATE	
DEGREE OF DISABILITY	11. DATES PATIENT UNABLE TO WORK DUE TO THIS ***** DISABILITY (Must have beginning date)	FROM : _____ TO : _____
	12. PATIENT CAN WORK LIGHT DUTY WITH RESTRICTIONS (Please attach current work restrictions)	FROM : _____ TO : _____
<p>"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."</p> <p>DATE COMPLETED _____ SIGNED _____ (ATTENDING PHYSICIAN) FAX _____ PHONE _____</p>		
<p>PRINT OR TYPE PHYSICIAN'S NAME STREET ADDRESS CITY OR TOWN STATE ZIP</p>		

TO BE COMPLETED BY: FINANCIAL INSTITUTION OR AGENT (IF DEALERSHIP, ATTACH PAYMENT VOUCHER)

CREDITOR'S	CERTIFICATE NO. (include prefix)	DATE OF ISSUE	AGENT'S CODE	NAME AND ADDRESS OF WRITING AGENT IF DIFFERENT FROM CREDITOR
		TERM	POLICY EXPIRES	
	1ST PAYMENT DUE	MONTHLY BENEFIT	LOAN NUMBER	EXISTING CLAIM NO.
	A&H COVERAGE DAY RETRO		IF REFINANCED, GIVE PREVIOUS POLICY NO.	PREVIOUS DATE OF ISSUE
	CREDITOR	CREDITOR ADDRESS		
	CREDITOR EMAIL	CITY ST ZIP		PHONE #
	DATE COMPLETED	COMPLETED BY		

CREDIT DISABILITY CLAIM FORM-STATEMENT OF INSURED

(PAYMENTS MAY BE DELAYED OR THE FORM MAY BE RETURNED IF YOU DO NOT ANSWER FULLY)

INSURED'S

FULL NAME _____	FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>	DATE OF BIRTH _____	SOCIAL SECURITY # _____	(AREA CODE) PHONE NO. _____
ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP) _____				EMAIL _____	
OCCUPATION _____			ARE YOU SELF-EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
EMPLOYER NAME _____			DO YOU WORK FOR A FAMILY MEMBER? YES <input type="checkbox"/> NO <input type="checkbox"/>		
EMPLOYER'S ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE : _____			DO YOU HAVE MORE THAN ONE EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>		
DATE YOU WERE INJURED _____	DATE YOUR SYMPTOMS BEGAN _____		DATE FIRST TREATED BY A PHYSICIAN _____		
WHAT DATE DID YOU LAST WORK? Mo _____ Day _____ Year _____	DESCRIBE YOUR DISABILITY _____				
IF YOU HAD AN ACCIDENT OR INJURY, PLEASE DESCRIBE HOW IT OCCURRED: _____			DID YOU RECEIVE TREATMENT AT THE EMERGENCY ROOM FOR YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
HAVE YOU EVER BEEN TREATED OR DISABLED BY THE SAME OR SIMILAR CONDITION BEFORE? YES <input type="checkbox"/> NO <input type="checkbox"/>					
IF YES, WHAT IS THE NAME OF THE PHYSICIAN THAT TREATED YOU? _____					
PROVIDE YOUR PRIMARY CARE PHYSICIAN'S NAME AND ADDRESS _____					
PROVIDE NAMES OF ANY PHYSICIANS SEEN IN THE PAST TWO YEARS --AND CONDITIONS THAT WERE TREATED:					
NAME	ADDRESS		CONDITION		
DATE RETURNED TO LIGHT DUTY WORK? (OR ESTIMATE) _____			DATE RETURNED TO FULL WORK?(OR ESTIMATE) _____		
ARE YOU NOW RECEIVING:	SOCIAL SECURITY DISABILITY	YES <input type="checkbox"/> NO <input type="checkbox"/>	HAVE YOU APPLIED FOR:	SOCIAL SECURITY DISABILITY	YES <input type="checkbox"/> NO <input type="checkbox"/>
	UNEMPLOYMENT	YES <input type="checkbox"/> NO <input type="checkbox"/>		UNEMPLOYMENT	YES <input type="checkbox"/> NO <input type="checkbox"/>
	OTHER BENEFITS _____			DATE APPLIED _____	
CERTIFICATION OF INSURED'S SIGNATURE					
I understand that this information will be used by Plateau Insurance Company or its legal representative, for the purpose of evaluating my claim. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge.					
DATE (must date) _____		INSURED'S SIGNATURE (must sign) _____			

EMPLOYER'S

YOUR EMPLOYER'S STATEMENT----EMPLOYER PLEASE ANSWER ALL QUESTIONS
(LEAVE THIS SECTION BLANK IF YOU ARE SELF-EMPLOYED, WE WILL WRITE TO YOU FOR ADDITIONAL INFORMATION)

I am the employer of the named insured, and for the purpose of furnishing information to the above Insurance Company to induce payment of claim of said employee, do certify as follows:

Date last worked at time of illness or injury _____	Hire Date: _____	Date returned and performed any part of his/her duties after illness or injury: _____		
Is this illness or injury covered by workmen's compensation? YES <input type="checkbox"/> NO <input type="checkbox"/>	If "Yes", give name, address and phone # of carrier _____		Date of Accident: _____	
In the past 3 years, has employee missed more than 5 consecutive days of work due to : substance abuse, back disorder, mental or nervous disorder? YES <input type="checkbox"/> NO <input type="checkbox"/>				
When recovered, will he resume work with you? YES <input type="checkbox"/> NO <input type="checkbox"/>	If not, why? _____		Was employee laid off? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, Date: _____	
Employee's Title _____	Average hours per week: _____	Employee's regular duties are: _____		
Company name _____	Name of person furnishing this information (please print) _____			
Address: _____	Phone # & Extension you can be reached: _____			
City, State, Zip _____	Email: _____	Date: _____		

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This Authorization was prepared by Plateau Insurance Company for purposes of obtaining information necessary to process a claim for benefits.

PHYSICIANS NAME OR FACILITY

ADDRESS

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), **ANY** licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, pharmacy benefit manager, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide **PLATEAU INSURANCE COMPANY** or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs, use of alcohol or HIV. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that my health provider may not condition treatment, payment, enrollment in the health plan or eligibility for benefits on my execution of this authorization.

I understand that **Plateau Insurance Company** may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand that the information disclosed by this authorization could be disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements.

This Authorization is valid from the date signed for the duration of the claim.

(Print Please) Name of Patient

Date of Birth

Signature of Patient, Authorized Representative, or Next of Kin

Date Signed

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Phone No.

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state or residence and then read the fraud language that pertains to your state. Thank you.

Alabama	Kansas	North Carolina	South Dakota
Arkansas	Louisiana	North Dakota	Texas
California	Massachusetts	Nebraska	Utah Vermont
Connecticut	Michigan	Nevada	Wisconsin
Georgia	Missouri	Puerto Rico	West Virginia
Iowa	Mississippi	Rhode Island	Wyoming
Illinois	Montana	South Carolina	

Generic Fraud Warning (to be used for above states only)

Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alaska, Delaware, Idaho, Indiana, Oklahoma

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.

Colorado, D.C., Hawaii, Maine, Tennessee, Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance coverage.

Arizona, Minnesota, New Jersey, New Mexico

Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment for a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon

Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Maryland

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

New Hampshire

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

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files 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.

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.