Here is the "Initial 7-day Disability Claim" form.

Please fill out according to the instructions on the packet.

Once all portions are filled out, the original forms need to be returned to me in tact so I can send off to the General Insurance Company to get your payment/s made. These claims take three weeks to process, so you will still need to make your monthly payment until the insurance is active.

The Credit Insurance will only pay up to $350/month on any loan. If your payment is over $350; the balance for the month is your responsibility. You will need to update us monthly with your situation so Nexis Financial can service your account properly.

PLEASE NOTE AGAIN TO RETURN PACKET TO NEXIS FINANCIAL
NOT
AMERICAN NATIONAL INSURANCE COMPANY

If you have any questions, please give us a call! Take care!

POLICY OR CERTIFICATE NUMBER

_____

(Please attach a copy.)

AMERICAN NATIONAL INSURANCE COMPANY
CREDIT INSURANCE CLAIMS DEPARTMENT – REGIONAL OFFICE
P.O. BOX 1580, MANDEVILLE, LA 70470
PHONE NUMBER: 800-779-5628

APPLICATION FOR CREDIT DISABILITY BENEFITS

Section A – Insured's Statement

Name _____ Date of Birth _____ Phone Number (_____) _____

Male/Female _____ E-mail Address _____

Street Address _____ City_____ State _____ ZIP _____

Mailing Address _____ City_____ State_____ ZIP _____

What is your business or occupation? _____ Name of employer or business _____

Address of employer or business _____ City _____ State _____ ZIP _____

Phone Number (_____)_____ Describe your specific duties to perform your job _____

_____

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

When did you first notice symptoms of your illness, or on what day did the injury occur? _____

How did the injury happen? _____ Have you had this or a similar condition before? ☐ Yes ☐ No

If "yes," what condition and when? _____

What date did you first see a physician? _____ Where? _____

Physician Name _____ Address _____ Phone Number (_____) _____

Has any other physician treated you for this injury or illness? ☐ Yes ☐ No If "yes," when _____

Name of treating physicians _____

Dates confined to hospital: Month_____ Day_____ Year_____ to Month_____ Day_____Year_____

First date you were entirely away from work due to current disability _____ Date you returned to work _____

Have you performed any work other than your usual occupation? ☐ Yes ☐ No If "yes," give nature of work and dates worked.

_____

Have you had any medical or surgical advice/treatment/consultation during the past 5 years for any other condition? ☐ Yes ☐ No

If "yes," what were you treated for? _____ When? _____

Physician Name _____ Address_____ Phone Number (____) _____

Are you receiving or entitled to receive any other disability benefits? ☐ Yes ☐ No If "yes," source _____

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/certificate be paid to the lending institution as listed on the policy/certificate, whose receipt for benefits that may be due me shall be a full acquittance of all my claims under the said policy/certificate. 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/Pharmacy Benefit Managers

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** _____

(over) **Signature**

Section B – Creditor Information

Loan Number _____ Name of Debtor _____ Social Security Number _____

Effective Date of Loan _____ Monthly Payment Amount $_____ Name of Creditor _____

Address _____ Branch Number _____ Phone Number _____

Section C – Statement of Attending Physician

Patient's Name _____

Is condition due to pregnancy? ☐ Yes ☐ No If "yes," describe complications _____

Diagnosis of disability – 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 or injury happen? _____

What diagnostic and/or surgical procedures were performed? _____

What treatments were prescribed? _____

Date patient was confined to a hospital: From _____ To _____

Name of hospital _____ Address _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "yes," when _____

Is patient still under your care for this condition? ☐ Yes ☐ No If "no," date discharged _____

For what have you previously treated patient? (state condition and dates) _____

How long have you been his/her physician? _____

Dates of treatment you have provided the patient in the past 90 days _____

In your opinion, when did the patient become unable to work due to disability? Month _____ Day _____ Year _____

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

Was patient referred to you? ☐ Yes ☐ No If "yes," please identify _____
(Name) (Address) (City) (ZIP) (Phone Number)

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

Address, City, State, ZIP **Phone Number**

Section D – Statement of Employer

Name of Company _____ Employee Name _____

Type of Employee: ☐ Full-Time ☐ Part-Time ☐ Seasonal Average hours worked per week _____ Date of hire _____

Description of duties _____ Do you have light duty available? _____

Do you classify employee's duties as light, medium, or heavy work? _____ Will job be held for employee? _____

First full day absent (due to disability) _____ First date returned _____

Did employee work any period between these dates? ☐ Yes ☐ No If "yes," list dates _____

Has employee filed a claim for this loss under worker's compensation? ☐ Yes ☐ No If "yes," list name, address, and phone number of carrier _____

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

Address of Employer **City** **State** **ZIP** **Phone Number** **Fax Number**