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 Lakeview Financial can service your account properly.

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

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

CREDIT INSURANCE GENERAL AGENCY AND RELATED SERVICES

ADMINISTERED BY AMERICAN NATIONAL INSURANCE COMPANY
P.O. BOX 1580 MANDEVILLE LA 70470-1580
800-779-5628

APPLICATION FOR DISABILITY BENEFITS

POLICY OR CERTIFICATE NO. _____
(Please attach a copy)

STATEMENT OF CLAIMANT

This is to certify that I am the insured under the above numbered contract, and for the purpose of applying for benefits under the contract, furnish the following information which I warrant to be true, complete and correct:

☐ Male Telephone No. ( ) _____

1. Name _____ ☐ Female Birth Date: Month ____ Day ____ Year _____
2. Address _____
   Street or P. O. Box City & State Zip Code
3. Occupation _____ Employer _____
   If unemployed, give last Occupation and Employer
4. Cause of Disability (Check One) Injury ☐ Sickness ☐ Describe Ailment _____
   a. When did current condition first appear? Hour _____ Month _____ Day _____ Year _____
   b. Have you had this condition before? _____ If so, when? _____
5. Treatment:
   a. Name of all physicians who have treated you for current conditions _____
   b. Date of first treatment: Month _____ Day _____ Year _____ Where _____
   c. Name of Hospital: _____ Address: _____
   d. Date confined to hospital: Month ____ Day ____ Year ____ to Month ____ Day ____ Year _____
   e. Was medical advice, consultation or treatment required or recommended during the six month period before the effective date of your indebtedness (Yes or No)? _____
   f. Was medical advice, consultation or treatment required or recommended during the six month period after the effective date of your indebtedness (Yes or No)? _____
6. First date you were entirely away from work due to current disability: Month ____ Day ____ Year _____
7. Date of first return to any part of your work: Month _____ Day _____ Year _____

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 be paid to the lending institution as listed on the policy, whose receipt for benefits that may be due me shall be a full acquittance of all my claim under the said contract.

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

I hereby authorize to permit the bearer representing American National Insurance Company or any of its subsidiaries to obtain a copy of my records pertaining to any and all medical practitioners, physician, pharmacists, hospitals, clinics, nurses, records custodians, employers, financial custodians, medical examiners/coroners, or insurance companies. I understand that the information I am authorizing to be released may include:

- Alcohol abuse & treatment and drug abuse & treatment,
- Pharmacy prescriptions,
- Psychiatric treatment,
- AIDS/HIV test results.

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 this 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 the 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, information re-disclosed may not be protected by HIPAA. I certify under penalty of perjury, that the information and Social Security Number provided are true and correct. I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process benefit payment requested on my policy.

Date _____ Claimant _____
Signature

(over)

CREDIT INSURANCE GENERAL AGENCY AND RELATED SERVICES
ADMINISTERED BY AMERICAN NATIONAL INSURANCE COMPANY
MANDEVILLE LA
STATEMENT OF LENDING INSTITUTION

Loan No.	Name of Debtor	Social Security No.	Age
Effective Date of Indebtedness	Termination Date	Term of Indebtedness Months	
Identifiable Insurance Charge to Debtor: LIFE $ DISABILITY $	Initial Total Indebtedness $	Insured Mo. Installment Payment $	
Name of Creditor Payee	Address No. & Street City State Zip	Telephone	

The debtor has been continuously covered by disability since _____, 20 _____

Branch Office No. _____ By _____
Signature Title

STATEMENT OF ATTENDING PHYSICIAN

1. Patient's Name _____ Address _____
2. Diagnosis-Please mention any complications: _____
3. Please advise of history pertinent to the CAUSE of this disability: _____
4. When did patient first consult you about this condition? _____
5. When did symptom appear according to patient? _____
6. What diagnostic and surgical procedures were performed? _____
7. What treatment was prescribed? _____
8. Date patient was confined to hospital: From _____ To _____
9. Name of hospital _____ Address _____
10. Number of times you have treated patient during the past 30 days: _____ Please document date(s) and location(s):
    At home _____ At Office _____ At hospital _____
11. In your opinion when did patient become totally disabled? Month _____ Day _____ Year _____
12. In your opinion when can or did patient resume any work? Month _____ Day _____ Year _____
13. Name of other attending physicians: _____
14. Telephone No: ( ) _____ Signed _____
    Physician Degree
    Date _____
    Address _____
    Street City & State Zip Code
    Physician's Full Name (Please Print): _____

STATEMENT OF EMPLOYER

Our employee, _____, Whose original date of employment was _____,
was disabled from work beginning at _____ a.m. p.m. _____ and did not return until _____ a.m. p.m. _____

Employer _____
Name of Company Street Address City & State Zip Code

Telephone No. ( ) _____ By _____
Signature Title

Date _____

ALL QUESTIONS MUST BE FULLY ANSWERED OR DELAY WILL RESULT