OneMain Solutions®

Underwritten by:
Merit Life Insurance Company
P.O. Box 2548, Fort Worth, TX 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
insclaims@omf.com

Insured's Name: ______________________________ Account/Policy # ______________________

Disability Claim Form Claim # ______________________ (if available)

Important Information

For Arizona residents only: "For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

For California residents only: "For your protection California law requires the following to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in 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 though you paid on time. If 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.

For Pennsylvania residents only: "Any person who, with the intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that can include fines and confinement in prison."

For residents of other states (NOTE: None of these notices apply to Oregon residents.): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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."

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Disability Claim Form - Instructions

Claim # ______________________
(if available)

1. Read, complete, sign, and date all applicable portions of the Statement of Insured.
2. Employer must complete and sign the Employer's Section. (Not needed for continuing submissions)
3. The Physician who can verify your disability must complete the Physician's Statement.
4. Send all pages of the completed, signed claim form and any attachments to the Insurance Claims Department as shown above. Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal / medical information.

Note: Altered forms cannot be accepted.

Statement of Insured - To be completed by Insured

Name

Complete mailing address **City** **State** **Zip**

Date of birth (MM / DD / YY) **Telephone #** **Last 4 of SSN**

Email address (optional)

Self employed ☐ **Yes** ☐ **No**

Date last worked ☐☐ / ☐☐ / ☐☐

Date unable to work due to disability ☐☐ / ☐☐ / ☐☐

Returned to work ☐ **Yes** ☐ **No**

If Yes, date returned ☐☐ / ☐☐ / ☐☐

☐ **Full Duty**
☐ **Light Duty**

Describe illness or injury

Have you had the same or similar illness or injury before ☐ **Yes** ☐ **No**
If yes, when

I affirm the information I have provided herein is accurate and complete.

Signature **Date** ☐☐ / ☐☐ / ☐☐

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Claim # ______________________
(if available)

Disability Claim Form - Statement of Insured - To be completed by Insured

AUTHORIZATION

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) Privacy regulations, 45 CFR § 164.508, I hereby authorize any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Railroad Retirement Board, Veterans Administration or any other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to above or any of its representatives for purposes of processing this claim.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may included treatment for physical and mental illness (except for psychotherapy notes which must be requested by separate authorization), alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. Initials [ ]

This authorization shall be valid for the duration of the claim. I have the right to revoke this authorization by providing a signed and dated, written notice to the insurance company above. Once this authorization is revoked, protected health information subject to this authorization will not be used or disclosed except to the extent that this authorization has already been relied upon. I understand that in executing this authorization the information disclosed may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance and Portability and Accountability Act (HIPPA). I understand that I have the right to retain a copy of this authorization and to inspect and receive any information disclosed under its terms. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature ______________________ **Date** __ __ / __ __ / __ __

Statement of Employer - To be Completed by Most Recent Employer

Date last worked __ __ / __ __ / __ __

On last work day, did employee work
☐ **Full Day** ☐ **Partial Day** ☐ **Not at all**

Date unable to work due to disability __ __ / __ __ / __ __

Date employee returned to work __ __ / __ __ / __ __

Original date of hire __ __ / __ __ / __ __

If terminated, date terminated __ __ / __ __ / __ __

Signature of Individual completing ______________________ **Date** ______________________

Printed name ______________________ **Title** ______________________

Company name ______________________

Complete mailing address ______________________ **City** ______________________ **State** ______ **Zip** ______

Telephone # ______________________ **Fax #** ______________________

Email address ______________________

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Claim # ____________________ (if available)

Disability Claim Form - Statement of Attending Physician - To be Completed by Attending Physician

Completed without expense to the Insurance company.

Patient unable to work due to disability ☐☐ / ☐☐ / ☐☐ **Through** ☐☐ / ☐☐ / ☐☐

Initial date of treatment ☐☐ / ☐☐ / ☐☐ **All subsequent treatment dates** ____________________

Frequency of visits ☐ **Weekly** ☐ **Monthly** ☐ **Other**

Primary diagnosis **ICD code(s)**

Contributing cause/complications of disability

Surgical or obstetrical procedures and dates

If pregnancy related, provide the estimated date of delivery and list any complications

If hospitalized, dates of hospitalization

Name of Hospital

Has patient ever had the same or similar condition ☐ **Yes** ☐ **No** **If yes, when** ____________________

Date symptoms first appeared or accident occurred

Is patient ☐ **"Totally Disabled" (Unable to perform any duties of his/her occupation)**
☐ **"Partially Disabled" (Can perform some of his/her duties)**

Approximate date patient will be able to return to work __________ ☐ **2-5 months** ☐ **6-12 months** ☐ **Over 12 months** ☐ **Never returning**

Name of referring physician, if any **Date of referral**

Referring physician's complete mailing address **City** **State** **Zip**

Signature of attending physician **Date**

Printed name

Complete mailing address **City** **State** **Zip**

Telephone # **Fax #**

Email address