American Health and Life Insurance Company
Underwritten and Administered by: American Health and Life Insurance Company
Securian Life Insurance Company
Administered by: OneMain Assurance Services, LLC
P.O. Box 2548
Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9582 | insclaims@omf.com

Insured's Name: _____ **Claim Number:** _____ **(if assigned)**

Account/Policy Number: _____

Disability Claim Form - 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 this 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 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.

For New York residents only: "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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Signature _____ **Date** (mm/dd/yy) _____

For Pennsylvania residents only: "Any person who, with 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, with 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 or any insurance representative doing so to a policyholder or claimant with regard to a settlement or award payable from proceeds may be reported to the department of regulatory agencies and may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that include fines and confinement in prison."

Usted puede obtener la versión en español de este formulario de reclamación en el sitio web de OneMain Solutions - www.onemainsolutions.com - Find a Form

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(if assigned)

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Disability Claim Form - Instructions	
1	❑ 1. Initial, sign, and date the Authorization. ❑ 2. Fully complete, sign, and date the Insured's Section **after initial waiting period has been met.** ❑ 3. Attending Physician's Section should be completed, signed, dated, and initialed by your attending physician after initial waiting has been met.
2	❑ Depending on your Certificate of Insurance's requirements, additional claim information may be required. ❑ To avoid delays in processing your claim, it is important to submit fully completed claim forms, **signed and dated after the initial waiting period has been met**. Altered claim forms may not be accepted. ❑ **A continuing claim form and medical documentation will be required during your claim period.** ❑ Please be aware email is not considered a secure method of delivery for personal/medical information.
3	Please return your completed claim form and supporting documents to us in one of the following ways: **Email:** insclaims@omf.com Please be sure to include your name and account number/claim number in the subject line of your email. **Upload** online: www.OneMainSolutions.com/forms **Mail**: OneMain Solutions P.O. Box 2548 Fort Worth, TX 76113-2548 **Fax:** 800-350-9582
	We are here to help! See our website for Frequently Asked Questions (FAQs). Our Customer Solutions team is available to assist you Monday through Friday, 8:00 am to 8:00 pm ET. Toll free: 800-307-0048 Chat: www.OneMainSolutions.com Text: 60223

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(if assigned)

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Disability Claim Form - Authorization
To be completed by insured. (Electronic signature not accepted)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) 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: American Health and Life Insurance Company for the administration of its policies or as the administrator for Merit Life Insurance Company policies; or to OneMain Assurance Services, LLC as the administrator for Securian Life Insurance Company policies, 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 include 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 (HIPAA). 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** (mm/dd/yy) _____

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Insured's Name: _____ **Claim Number:** _____ **(if assigned)**

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Disability Claim Form
Insured's Section - To be completed by insured after waiting period has been met.

Mailing address	City	State	Zip

Telephone number	Date of birth (mm/dd/yy)	Last 4 of SSN

Employer's name	Employer's telephone number

Are you self employed? ❑ Yes ❑ No

Date last worked (mm/dd/yy)	Date unable to work due to disability (mm/dd/yy)

Have you returned to any type of work? ❑ Yes ❑ No

If yes, date returned (mm/dd/yy)

❑ Full duty
❑ Partial 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** (mm/dd/yy) _____

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Disability Claim Form
Statement of Attending Physician - To be completed by attending physician.
Completed without expense to the insurance company.

Date patient unable to work due to disability	From (mm/dd/yy)	Through (mm/dd/yy)
Initial date of treatment for diagnosis (mm/dd/yy)		Date symptoms first appeared or accident occurred (mm/dd/yy)
All subsequent treatment dates (mm/dd/yy)		
Primary diagnosis		ICD code(s)
Contributing cause/complications of disability		
Surgical or obstetrical procedures and dates (mm/dd/yy)		
If pregnancy related, provide estimated date of delivery and list any complications		
If hospitalized, name of hospital and dates of hospitalization		
Has patient ever had the same or similar condition? ❑ Yes ❑ No	If yes, when?	
Name of referring physician, if any		Date of referral (mm/dd/yy)
Referring physician's mailing address	City	State Zip

Is patient ❑ "Totally Disabled" (unable to perform any duties of their occupation)
❑ "Partially Disabled" (can perform some of their duties)

Approximate date patient will be able to return to work (mm/dd/yy) _____

❑ 2-3 months ❑ 4-6 months ❑ 7-12 months ❑ over 12 months ❑ Never returning

Has patient remained under your medical care during this period of disability?
Physician must answer and initial response. ❑ **Yes** _____ ❑ **No** _____

Physician's mailing address	City	State	Zip
Telephone number	Fax number	Email address	
Physician's printed name			
Signature of attending physician		Date (mm/dd/yy)	

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Important Notice from OneMain Financial About Credit Insurance Claims

If you apply for credit disability or credit involuntary unemployment insurance benefits, here's a look at what you can expect as your claim moves through the process and what you'll need to do to get the maximum benefits if your claim is approved.

File the Completed Claim Form(s) and Include All Required Documentation.

See Claim Form Instruction page for requirements.

While You're Waiting
When you file a claim, you're still responsible for making your monthly loan payments. **If you've scheduled recurring loan payments, they'll continue unless you stop them.**

When a claim is filed, the insurance company will get in touch with you once a claim decision has been made.

Although the insurance company strives to process claims as quickly as they can, sometimes gathering the information it needs can take some time. If you have filed a claim and it is approved, your benefits will be paid directly to us by the insurance company. Those benefit payments will be applied to your account as of the date they are received, unless otherwise required by law, for as long as you receive benefits.

Do You Need a Refund?
If a claim you submitted is approved, and you've already made loan payments for the period that the insurance company has covered causing your account to be paid ahead, you can ask OneMain Financial to refund the amount paid ahead. If you don't, the claim benefits will be applied as advance payments on your loan, which means your loan could be paid off before the end of your term, or before you've received all your potential credit insurance benefits.

If you find yourself in this situation, you can request a refund of the amount paid ahead on your account. To request a refund or if you have any questions, please get in touch with us by contacting your local OneMain Financial branch or by calling the telephone number listed on your statement.