

Instructions for Completing Accident and Health Claim Form

We are sorry to hear of your difficulties. Please assist us in preventing unnecessary delays in processing your claim by observing the following instructions when completing the form.

1. The insured's statement must be fully completed, signed and dated by you. Please make sure that you list all physicians who have treated you in the past, including family physicians. If necessary, you may list this information on a separate sheet of paper and attach it to the claim form.
2. The physician's statement must be fully completed and signed by the physician who is disabling you. The physician must initial all revisions and additions to this statement.
3. The employer's statement must be fully completed, signed and dated by your employer; your most recent employer if you are unemployed; officer of the labor union if you are a member and contract through the union for work; or yourself if you are self-employed.
4. YOU MUST SUBMIT A COPY OF THE CERTIFICATE OF INSURANCE with your completed claim form. This certificate is for verification of coverage. In addition, you must make sure that the full name and address of the creditor (lien holder) and the loan/account number is included.
5. Please sign the attached "Release of Information Authorization" which is required to comply with privacy laws and allows us to obtain the information needed to process your claim. Please do not list any specific entities, as we will add that information after determining what information, if any, is needed.

Please mail completed claim form to: Enterprise Life Insurance Company
P.O. Box 167667
Irving, Texas 75016-7667

Upon receipt of this information, your claim will be given our immediate attention. It may be necessary to conduct a routine investigation to obtain additional information that will assist us in evaluating your claim. In the meantime, you should notify your creditor that you will be submitting a claim; however, please remember that you are responsible for making your payments on time until we have advised you benefits will be issued.

If you have any questions or need additional information, please contact our credit claims department at (800) 527-1984, Ext. # 8702.

Sincerely,
Credit Claims Department

ENTERPRISE LIFE INSURANCE COMPANY/UNION SECURITY LIFE INSURANCE COMPANY

P.O. BOX 167667 IRVING, TEXAS 75016-7667
 972-445-8300, ext. #8702 OR 800-527-1984, ext. #8702
****ACCIDENT AND HEALTH INSURANCE CLAIM FORM****

INSTRUCTIONS TO INSURED

1. Complete and sign STATEMENT OF THE INSURED and AUTHORIZATION.
2. Have physician complete and sign the PHYSICIAN'S STATEMENT OF DISABILITY.
3. Have employer complete and sign the EMPLOYER'S STATEMENT.
4. A copy of the Disability Insurance Policy MUST BE ATTACHED.

ALL QUESTIONS MUST BE ANSWERED BEFORE CLAIM WILL BE CONSIDERED FOR PAYMENT.

“WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.”

LIENHOLDER (WHERE YOU MAKE YOUR CAR PAYMENTS) _____
 ADDRESS TO MAIL PAYMENTS _____ CITY _____ STATE _____ ZIP _____
 PHONE # _____ AUTO LOAN # _____ PAYMENT AMOUNT \$ _____

STATEMENT OF THE INSURED

Name In Full _____ DOB: _____ SS#: _____ HT: _____ Wt: _____

Physical Address _____ City _____ State _____ Zip _____

Phone #: _____ Vehicle Year, Make, Model & Color: _____

1. What is the cause of your disability? If the result of an accident, please give details, place, date, and time. _____

2. When and Where were you first treated by a physician? _____ at _____
 (Doctor's Office, Hospital, or Elsewhere)

3. Physician's name, address and phone # _____
 (If more than one, give name & address of each & periods during which each treated you)

4. Hospital name, address and phone # _____

5. Admission Date: _____ Discharge Date: _____

6. Have you ever had the same or similar illness before? _____ Date: _____

7. List ANY Doctors/Hospitals seen in the last 3 years. Please list your family physician first.

Doctor/Hosp. Name	Doctor/Hosp. Full Address	Doctor/Hosp. Phone#	Condition Treated	Dates Treated

8. Please list all medications you are currently taking: _____

9. When did you cease work entirely? Date: _____ Have you returned to work? Yes/No If Yes, Date: _____

10. What is your occupation? _____ Duties: _____

11. Have you had a previous claim with our company? Yes/No If Yes, Claim #'s: _____

I hereby certify that the foregoing answers are complete and true. It is agreed that the furnishing of this form or its acceptance by the Company as proof does not constitute an admission of any liability, nor a waiver of any of the conditions of the insurance contract.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, group policy holder, government authority, financial institution, or any past or present employer, to furnish Enterprise Life Insurance Company/Union Security Life Insurance Company or their representatives, any information related to my health, medical history, diagnosis, treatment, employment, or financial condition, for the purpose of determining my insurability or to process a claim for benefits. I further authorize the release of any such information to insurance companies, medical facilities, employers, or other entities as necessary to determine insurability or process a claim for benefits. The information authorized for release may include information that could be considered information about communicable or venereal diseases, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, alcohol or chemical dependency, mental or nervous disorders, the human immunodeficiency virus, and acquired immune deficiency syndrome. I understand I have the right to receive a copy of this authorization, a photocopy of this authorization shall be as valid as an original, and this authorization shall remain valid for two years from the date of my signature.

Date _____ Signature of the Insured (Claim can not be processed without signature)

PHYSICIAN'S STATEMENT OF DISABILITY

Patient's Name _____ Social Security Number _____ Date Of Birth _____

1. a) Please list all disabling Conditions/Diagnosis: _____
- b) Does this disability result from an accident? Yes No Date: _____
- c) When did symptoms first appear? _____
- d) Please list any past medical history related to current condition(s): _____
- e) Please list any past medical history unrelated to current conditions(s): _____
- f) Current medications: _____
- g) If disability is due to pregnancy, please describe all complications and indicate the actual/expected date of delivery: _____
- h) If patient was referred by another physician, please list referring physician's name, address & phone #: _____

2. **DATES OF TREATMENT: (List of all treatments/visits):** _____

3. **NATURE OF TREATMENT: (Including type and date of surgery and medications prescribed, if any)** _____

Has patient been hospitalized? Yes No Admission Date ___/___/___ Discharge Date ___/___/___

If yes, give name, address and phone # of hospital: _____

4. PROGNOSIS

- a) Is patient disabled from: Patient's Job? Yes No Any other Work? Yes No
- b) Give date disability began: _____
- c) Give date patient did or is anticipated to return to work: _____
- d) Restrictions: Lifting _____ lbs. Standing _____ Hrs. Sitting _____ Hrs. Walking _____ % Per Day
Repetitive Bending Yes No Squatting Yes No Stooping Yes No
Any other restrictions: _____
- e) What level of work is the patient capable of performing?
 Heavy Medium Light Sedentary None

Physician's Signature (Must Be M.D or D.O)

Printed Name

Date

Physician's Address

City

State

Zip

Phone Number

EMPLOYER'S STATEMENT

Employee's Name: _____ SS#: _____ Occupation: _____

1. Date last worked: _____ Has employee returned to work? Yes No If yes, Date: _____
2. Job Requirements: Lifting _____ Lbs. Standing _____ Hrs. Sitting _____ Hrs. Walking _____ % Per Day
Repetitive Bending Yes No Squatting Yes No Stooping Yes No
3. What level of work does the employees regular job duties require? Heavy Medium Light Sedentary
4. How many hours per week does employee normally work? _____ Normal work hours: From: _____ To: _____
5. When recovered, will he/she resume work with you? Yes No If Yes, Date _____ If No, explain: _____
6. Employee's original date of employment (hire date): _____ If terminated, date of termination: _____
7. Has employee been off work for 15 or more days due to disability (injury or sickness) within the past three years?
 Yes No If yes, please provide the dates and reasons off work: _____
8. Is light duty work available for this employee? Yes No If Yes, Date available: _____
9. Compensation Case? Yes No Name of Worker's Compensation Insurance: _____
Date of injury: _____ Worker's Comp. Ins. Phone #: _____ Case #: _____
10. Name of Business/Employer: _____ Employer Phone #: _____
11. Employer's Full Address: _____

Signature Of Employer

Printed Name

Title

Date

ENTERPRISE LIFE INSURANCE COMPANY

RELEASE OF INFORMATION AUTHORIZATION

Insured: _____

SSN: _____ **DOB:** _____

I authorize any physician, hospital, insurance company, employer, contractor, financial or educational institution, and/or any specific entities indicated, to release any information regarding medical history, financial condition, education or employment history to Enterprise Life Insurance Company ("ELIC") or Union Security Life Insurance Company ("USLIC").

SPECIFIC ENTITIES (if known): _____

The medical information I authorize for release includes the following: medical history & physical, admission & registration, consultation & evaluation reports, doctor's orders & progress notes, laboratory/pathology reports, radiology/x-ray reports, operative/procedure reports, emergency room records and discharge summaries. The information I authorize for release may include information regarding mental health or illness, chemical or alcohol dependency, and sexually transmitted, communicable or venereal diseases which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

I understand that any of the above information requested by ELIC/USLIC will be used for the purpose of evaluating eligibility for insurance coverage and any claims for life or disability benefits made on behalf of the insured. I understand that once the above information is provided to ELIC/USLIC, it may be re-disclosed and may not be protected by federal privacy laws or regulations. I understand that it is ELIC/USLIC's policy not to release any information to third parties for any reason other than to evaluate eligibility for insurance or a claim for benefits.

I understand that authorizing the disclosure of information is voluntary and I can refuse to sign this authorization; however, I also understand that a refusal may result in ELIC/USLIC being unable to determine eligibility for coverage or benefits. I also understand that, as set forth in the HIPAA Privacy rules (45 CFR 164), my healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present the written revocation to ELIC/USLIC. I understand that the revocation will not apply to an insurance company when the law provides the insurer with the right to contest a claim under the policy or to the extent that action has already been taken in reliance upon the authorization.

The information that I authorize for release shall include information up to 5 years prior to the date of my signature on this authorization, unless otherwise specified.

I also understand that this authorization will expire 5 years after the date of my signature, unless otherwise revoked. A photocopy of this authorization shall be as valid as the original.

DATE: _____ **SIGNATURE:** _____

RELATIONSHIP TO INSURED: _____