



# INITIAL BENEFIT VERIFICATION FORM

Benefit Activation Department, PO Box 977122, Miami, FL 33197-7122

LOAN NUMBER

**INSTRUCTIONS: Find the type of occurrence below. Please make sure the required sections are completed in full and any required documents are attached. An incomplete form will be returned, delaying the processing of your benefit activation.**

<b>DISABILITY</b>
<b>If Covered Person</b> (as described in Your Plan Information) <b>is disabled:</b>
1. Complete and sign Sections 1 and 2.
• <b>If receiving Social Security Disability (SSDI), please provide us with a copy of the award letter or verification of SSDI.</b>
2. Have the <b>employer</b> at the time of the Event complete Section 3 ( <b>disregard employment verification if retired</b> ).
• <b>If self-employed</b> , complete Section 3 and attach a <b>copy of the business license or bankruptcy papers.</b>
3. Have the <b>treating physician</b> complete Section 4.

<b>UNEMPLOYMENT</b>
<b>If Covered Person</b> (as described in Your Plan Information) <b>is unemployed:</b>
1. Complete and sign Sections 1 and 2.
2. Have the <b>employer</b> at the time of the Event complete Section 3 ( <b>disregard employment verification if retired</b> ).
3. Attach a copy of state Unemployment or strike benefit check(s) or Registration Card or letter from a recognized Employment Agency or Job Service for all months unemployed.

<b>DEATH</b>
<b>If Covered Person</b> (as described in Your Plan Information) <b>is deceased:</b>
1. Complete and sign Sections 1 and 2.
2. Attach a certified copy of the death certificate.

<b>SECTION 1 - COVERED PERSON'S INFORMATION</b>				<b>PLEASE PRINT</b>	
NAME OF CREDITOR		LOAN ACCOUNT NUMBER		ACTIVATION NUMBER (Internal use only)	
NAME OF COVERED PERSON			TELEPHONE NUMBER (DAY) ( )		TELEPHONE NUMBER (EVENING) ( )
STREET ADDRESS/APT. #		CITY	STATE	ZIP CODE	EMAIL ADDRESS (IF AVAILABLE)

<b>SECTION 2 - AFFECTED PERSON INFORMATION</b>						<b>PLEASE PRINT</b>	
NAME					AFFECTED PERSON IS		
					<input type="checkbox"/> Covered Person <input type="checkbox"/> Other		
STREET ADDRESS/APT. #		CITY	STATE	ZIP CODE	TELEPHONE NUMBER (DAY) ( )		TELEPHONE NUMBER (EVENING) ( )
DATE OF EVENT / /		TYPE OF EVENT <input type="checkbox"/> Death <input type="checkbox"/> Disability <input type="checkbox"/> Unemployed			IF UNEMPLOYED, DO YOU QUALIFY FOR UNEMPLOYMENT BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PLACE OF EMPLOYMENT (NOT REQUIRED IF RETIRED OR SELF-EMPLOYED)							

<b>AUTHORIZATION</b>
I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, government authority, or any past or present employer to furnish American Bankers Management Company or its representatives as requested, any information related to my health, medical history, diagnosis, treatment, or employment. I understand that I have the right to receive a copy of this authorization. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain valid for the remaining term of activation.

**Any person who knowingly and with intent to defraud any corporation or person, files a statement containing any materially false information, or conceals for the purpose of misleading information concerning any fact, material thereto, commits a fraudulent act, which is a crime, and is subject to criminal prosecution and civil penalties.**

COVERED PERSON'S SIGNATURE (REQUIRED)		SOCIAL SECURITY NUMBER		DATE	
<b>X</b>		- -		/ /	

**SECTION 3 - EMPLOYER STATEMENT** **PLEASE PRINT**

**TO BE COMPLETED BY YOUR EMPLOYER OR UNION REPRESENTATIVE**

EMPLOYEE'S NAME		DATE HIRED / /	NUMBER OF HOURS WORKED PER WEEK	
REASON FOR INTERRUPTION OF EMPLOYMENT				
<input type="checkbox"/> Laid Off	<input type="checkbox"/> Terminated	<input type="checkbox"/> Assignment Ended	<input type="checkbox"/> Military Duty	<input type="checkbox"/> Other _____
<input type="checkbox"/> Quit	<input type="checkbox"/> Resigned	<input type="checkbox"/> Disability		
PLEASE EXPLAIN REASON FOR INTERRUPTION OF EMPLOYMENT				
LAST DAY WORKED / /	DATE RETURNED TO WORK / /	TYPE OF EMPLOYMENT		
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Military <input type="checkbox"/> Self-Employed				
NAME OF COMPANY		TELEPHONE NUMBER ( )	EXTENSION	FAX NUMBER ( )
STREET ADDRESS		CITY	STATE	ZIP CODE
COMPLETED BY (PRINT NAME)	SIGNATURE <b>X</b>	TITLE	DATE / /	

**SECTION 4 - PHYSICIAN STATEMENT** **PLEASE PRINT**

**TO BE FURNISHED WITHOUT EXPENSE TO AMERICAN BANKERS MANAGEMENT COMPANY**

PATIENT'S FULL NAME		DIAGNOSIS CODE(S)		
		<input type="checkbox"/> ICD-9 _____ <input type="checkbox"/> CPT _____ <input type="checkbox"/> DSM III _____		
STREET ADDRESS/APT. #		CITY	STATE	ZIP CODE
OBJECTIVE DIAGNOSIS/FINDINGS				
HAS PATIENT BEEN HOSPITALIZED			NAME OF HOSPITAL	
<input type="checkbox"/> Yes <input type="checkbox"/> No                   FROM / /                   THROUGH / /				
HOSPITAL STREET ADDRESS		CITY	STATE	ZIP CODE
		TELEPHONE NUMBER ( )		
GIVE ALL DATES OF TREATMENT SINCE ONSET OF CONDITION				
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK / /	IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK / /	
GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)		GIVE EXACT DATES OF PARTIAL DISABILITY		
FROM / / TO / /		FROM / / TO / /		
IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT		IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED		
<input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-Disabled		<input type="checkbox"/> 1-2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Longer than 9 months <input type="checkbox"/> Undetermined		
PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)				
<input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work; No restrictions. (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity. (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)				
Remarks:				
PROGNOSIS/COMMENTS				
<b>I hereby certify that the above-described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.</b>				
PHYSICIAN'S NAME (PRINT NAME)	PHYSICIAN'S SIGNATURE <b>X</b>	DEGREE	MEDICAL I.D. NUMBER	DATE / /
STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )
				FAX NUMBER ( )

Form must be fully completed and signed or stamped by Physician's office.

**FAX COMPLETED FORM AND ANY ATTACHMENTS TO 305-259-4575 OR MAIL TO:**

USAA Debt Protection Plan  
 Benefit Activation Department  
 PO Box 977122  
 Miami, FL 33197-7122

After 15 business days, the activation status may be verified through the automated inquiry system, Monday - Friday 9:00 a.m. - 6:00 p.m. Eastern Time, by calling 1-800-859-0568