PLATEAU INSURANCE COMPANY

P.O. BOX 7001 CROSSVILLE, TENNESSEE 38557-7001 PHONE # 800-752-8328

ADMINISTRATOR FOR: GUARANTEE TRUST LIFE INSURANCE COMPANY - INDIVIDUAL ASSURANCE COMPANY
KENTUCKY HOME LIFE INSURANCE COMPANY - INVESTORS HERITAGE LIFE INSURANCE COMPANY
MINNESOTA LIFE INSURANCE COMPANY- A SECURIAN COMPANY

CLAIMS DEPARTMENT FAX NO: (931) 459-3113 **EMAIL: PLATEAU.CLAIMS@PLATEAUGROUP.COM**

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

TO BE FURNISHED WITHOUT EXPENSE TO THE INSURANCE COMPANY

1. PATIENT'S FULL NAME _____ AGE _____

2. ADDRESS _____
STREET CITY STATE ZIP

******** THE PURPOSE OF THIS FORM IS TO CERTIFY YOUR PATIENT'S DISABILITY AND TIME OFF WORK

DIAGNOSIS

3. DIAGNOSIS CAUSING DISABILITY (Describe any complications)	
4. DATE SYMPTOMS FIRST APPEARED OR INJURY OCCURRED	DATE:
5. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	DATE: Was the insured a new patient on that date? YES ☐ NO ☐
6. WHO REFERRED PATIENT TO YOU?	
WHO IS INSURED'S PRIMARY CARE PHYSICIAN?	
7. IS CONDITION DUE TO NORMAL PREGNANCY? YES _____ NO _____	ARE THERE PREGNANCY COMPLICATIONS? ☐ YES ☐ NO ESTIMATED DELIVERY DATE :

PHYSICIAN'S TREATMENTS

8. DATES YOU TREATED PATIENT FOR THIS CONDITION: (** if too numerous, please attach an itemized bill)	DATES:
9. IF HOSPITALIZED, GIVE DATE, NAME, AND ADDRESS OF HOSPITAL:	ADMITTED: _____ DISCHARGED: _____ HOSPITAL: _____ SURGERY DATE: _____ PROCEDURE : _____

DEGREE OF DISABILITY

10. NEXT APPOINTMENT DATE	
.11. DATES PATIENT UNABLE TO WORK DUE TO THIS ***** DISABILITY (Must have beginning date)	FROM : TO :
12. PATIENT CAN WORK LIGHT DUTY WITH RESTRICTIONS (Please attach current work restrictions)	FROM : TO :

"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."

FAX _____

DATE COMPLETED _____ SIGNED _____ PHONE _____
(ATTENDING PHYSICIAN)

PRINT OR TYPE PHYSICIAN'S NAME STREET ADDRESS CITY OR TOWN STATE ZIP

TO BE COMPLETED BY THE FINANCIAL INSTITUTION OR AGENT/DEALERSHIP

CREDITOR'S

CERTIFICATE NO. (include prefix)	DATE OF ISSUE	AGENT'S CODE	NAME AND ADDRESS OF **WRITING AGENT** IF DIFFERENT FROM CREDITOR
	TERM	POLICY EXPIRES	
1ST PAYMENT DUE	MONTHLY BENEFIT	LOAN NUMBER	EXISTING CLAIM NO.
A&H COVERAGE DAY RETRO		IF REFINANCED, GIVE PREVIOUS POLICY NO.	PREVIOUS DATE OF ISSUE
CREDITOR		CREDITOR ADDRESS	
CREDITOR EMAIL		CITY ST ZIP	PHONE #
DATE COMPLETED	COMPLETED BY		

CREDIT DISABILITY CLAIM FORM-STATEMENT OF INSURED

(PAYMENTS MAY BE DELAYED OR THE FORM MAY BE RETURNED IF YOU DO NOT ANSWER FULLY)

INSURED'S

FULL NAME FEMALE ☐ MALE ☐	DATE OF BIRTH	SOCIAL SECURITY #	(AREA CODE) PHONE NO.
ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP)		EMAIL	

OCCUPATION _____ ARE YOU SELF-EMPLOYED? YES NO

EMPLOYER NAME _____ DO YOU WORK FOR A FAMILY MEMBER? YES NO

EMPLOYER'S ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE : DO YOU HAVE MORE THAN ONE EMPLOYER? YES NO

DATE YOU WERE INJURED	DATE YOUR SYMPTOMS BEGAN	DATE FIRST TREATED BY A PHYSICIAN
WHAT DATE DID YOU LAST WORK? Mo Day Year	DESCRIBE YOUR DISABILITY	
IF YOU HAD AN ACCIDENT OR INJURY, PLEASE DESCRIBE HOW IT OCCURRED:	DID YOU RECEIVE TREATMENT AT THE EMERGENCY ROOM FOR YOUR INJURY? YES NO	

HAVE YOU EVER BEEN TREATED OR DISABLED BY THE SAME OR SIMILAR CONDITION BEFORE? YES NO

IF YES, WHAT IS THE NAME OF THE PHYSICIAN THAT TREATED YOU?

PROVIDE YOUR PRIMARY CARE PHYSICIAN'S NAME AND ADDRESS

PROVIDE NAMES OF ANY PHYSICIANS SEEN IN THE PAST TWO YEARS –AND CONDITIONS THAT WERE TREATED:

NAME	ADDRESS	CONDITION

DATE RETURNED TO LIGHT DUTY WORK? (OR ESTIMATE) _____ **DATE RETURNED TO FULL WORK?(OR ESTIMATE)** _____

ARE YOU NOW RECEIVING: SOCIAL SECURITY DISABILITY YES NO

UNEMPLOYMENT YES NO

OTHER BENEFITS_____

HAVE YOU APPLIED FOR: SOCIAL SECURITY DISABILITY YES NO

UNEMPLOYMENT YES NO

DATE APPLIED _____

CERTIFICATION OF INSURED'S SIGNATURE

I understand that this information will be used by Plateau Insurance Company or its legal representative, for the purpose of evaluating my claim. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge.

DATE (must date) _____ **INSURED'S SIGNATURE** (must sign) _____

EMPLOYER'S

YOUR EMPLOYER'S STATEMENT----EMPLOYER PLEASE ANSWER ALL QUESTIONS

(LEAVE THIS SECTION BLANK IF YOU ARE SELF-EMPLOYED, WE WILL WRITE TO YOU FOR ADDITIONAL INFORMATION)

I am the employer of the named insured, and for the purpose of furnishing information to the above Insurance Company to induce payment of claim of said employee, do certify as follows:

Date last worked at time of illness or injury	Hire Date:	Date returned and performed any part of his/her duties after illness or injury:	
Is this illness or injury covered by workmen's compensation? YES NO		If "Yes", give name, address and phone # of carrier	Date of Accident:
In the past 3 years, has employee missed more than 5 consecutive days of work due to : substance abuse, back disorder, mental or nervous disorder? YES NO			
When recovered, will he resume work with you? YES NO	If not, why?	Was employee laid off? YES NO If yes, Date:	
Employee's Title	Average hours per week:	Employee's regular duties are:	
Company name		Name of person furnishing this information (please print)	
Address:		Phone # & Extension you can be reached:	
City, State, Zip		Email:	Date:

PLATEAU INSURANCE COMPANY

P.O. Box 7001 Crossville, TN 38557-7001

ADMINISTRATOR FOR: GUARANTEE TRUST LIFE INSURANCE COMPANY - INDIVIDUAL ASSURANCE COMPANY
KENTUCKY HOME LIFE INSURANCE COMPANY - INVESTORS HERITAGE LIFE INSURANCE COMPANY
MINNESOTA LIFE INSURANCE COMPANY- A SECURIAN COMPANY

This Authorization was prepared by Plateau Insurance Company for purposes of obtaining information necessary to process a claim for benefits.

PHYSICIANS NAME OR FACILITY **CERTIFICATE #**

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), ANY licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, pharmacy benefit manager, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide PLATEAU INSURANCE COMPANY or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs, use of alcohol or HIV. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that my health provider may not condition treatment, payment, enrollment in the health plan or eligibility for benefits on my execution of this authorization.

I understand that Plateau Insurance Company may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand that the information disclosed by this authorization could be disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements.

This Authorization is valid from the date signed for the duration of the claim.

(Print Please) Name of Patient Date of Birth

Signature of Patient, Authorized Representative, or Next of Kin Date Signed

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient Phone No.

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state or residence and then read the fraud language that pertains to your state. Thank you.

Alabama	Kansas	North Carolina	South Dakota
Arkansas	Louisiana	North Dakota	Texas
California	Massachusetts	Nebraska	Utah Vermont
Connecticut	Michigan	Nevada	Wisconsin
Georgia	Missouri	Puerto Rico	West Virginia
Iowa	Mississippi	Rhode Island	Wyoming
Illinois	Montana	South Carolina	

Generic Fraud Warning (to be used for above states only)
Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alaska, Delaware, Idaho, Indiana, Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Colorado, D.C., Hawaii, Maine, Tennessee, Virginia
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance coverage.

Arizona, Minnesota, New Jersey, New Mexico
Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment for a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon
Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maryland
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement or claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Washington
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.