CUNA MUTUAL GROUP
CUNA Mutual Insurance Society
P.0. Box 667
Waverly, IA 50677-0667
Phone: 800/621-6323 ▪ Fax: 608/218-1998

INITIAL CLAIM REPORT FOR CREDIT DISABILITY INSURANCE

INSTRUCTIONS:
1. **Credit Union complete Part 1**
2. **Member complete Part 2**
3. **Doctor complete reverse side**
4. **Mail or fax completed form to CUNA Mutual Group**

☐ **Check here if you need an additional supply of this form.**

PART 1 - CREDIT UNION INFORMATION ★ **denotes mandatory for loan information**

Contract Number	Branch	Date	★Loan Number	☐ Open End ☐ Closed End	☐ Open End ☐ Closed End
Credit Union Name			Certificate Number		
			★Loan Purpose		
Address			★Date Loan Granted		
			★Date Loan Insured		
City	State	Zip	★Loan Balance on date of Loss		
			★Scheduled Payment 'Amount	$	$
Phone ( ) Ext.	Contact Person		★Payment Frequency	☐ WK ☐ BW ☐ SM ☐ MO	☐ WK ☐ BW ☐ SM ☐ MO
Prior Insurance Carrier			★Date Last Premium Paid Prior to Disability		
Member's Last Name	First Name	Middle	★Last Premium Amt Prior to Disability	$	$
Address			★Does Payment Amt Include Premium?	☐ YES ☐ NO	☐ YES ☐ NO
City	State	Zip	★Interest Rate	%	%
			★Is Rate Annual?	☐ YES ☐ NO	☐ YES ☐ NO
Phone ( )	Date of Birth		Security		
			★Pmt Due Date(s)		
Social Security Number	Account Number		★List any money advanced or refinanced in the six months prior to the date of disability.	Date	Date
				Amount $	Amount $
DATE OF LOSS	Number of Insured Loans on Date of Disability:			Pmt Before Advance $ ☐WK ☐BW ☐SM ☐MO	Pmt Before Advance $ ☐WK ☐BW ☐SM ☐MO
If one or more loans is a Credit Card, please submit statements from six months prior to the disability date through the month the disability began.			**If no advances, indicate N/A in the date fields.**	Date	Date
				Amount $	Amount $
If there are more than two advances per loan, please attach a separate sheet of paper.				Pmt Before Advance $ ☐WK ☐BW ☐SM ☐MO	Pmt Before Advance $ ☐WK ☐BW ☐SM ☐MO

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits a statement of claim containing any false, incomplete or misleading information is guilty of a crime, and in some states subject to criminal or civil penalties, or guilty of a felony.

PART 2 - MEMBER'S INFORMATION

Employer Name	Employer Phone ( )	
Employer Address	Employer Fax ( )	
Occupation at Time of Disability Are you self employed? ☐ Yes ☐ No	Describe Job Duties	Job class: ☐ light ☐ medium ☐ heavy ☐ very heavy
Number of hour required to work per week prior to disability:		
Last Full Day Worked: / Date Disability Began:	Describe Cause of Disability	
Describe any special skills or training:		

Please circle the highest level of education completed:
Primary School 1 2 3 4 5 6 7 8 **High School** 9 10 11 12 GED **College** 1 2 3 4 +

Have you returned to work? ☐ Yes ☐ No	If **Yes**, exact date you returned to work:	Was it: ☐ Regular Duty Hrs per day: ☐ Restricted Hrs per wk:
If you have returned to work, please describe your job duties:	If **No**, please give an estimated recovery date:	Please describe your current daily activities:

Are you receiving any of the following:

Workers Compensation	☐ **Yes**	☐ **No**
Unemployment	☐ **Yes**	☐ **No**
Disability Retirement	☐ **Yes**	☐ **No**
Social Security Disability	☐ **Yes**	☐ **No**

If you are receiving any of the above, Date started: Date Ended:

If yes, contact name and case #: _____
Workers Comp Phone: _____
Other Benefits: _____
If you are receiving Social Security Disability, please send a copy of the original Notice of Award letter and the Medical Findings.

Please list all Health Care Providers seen for this condition in the past 12 months: (Attach another sheet of paper if necessary)

Physician's Name	City	State	Phone	Date treated from	Date treated to

IMPORTANT: Be sure to sign and date the Authorization for Release of Medical and Employment Information on top of the reverse side. Without your signature, your claim may be delayed

Authorization for Release of Medical and Employment Information: I authorize any health car providers, physician, medical practitioner, psychologist, chiropractor, hospital, clinic, pharmacy benefit manager or other pharmaceutical firm, insurance or reinsuring companies, the Medical Information Bureau, Inc., consumer reporting agency, Social Security Administration, financial institution, or employer having information about the history, diagnosis, treatment and prognosis with respect to any physical or mental condition, prescription drug records, financial status, employment status, or other relevant information of mine to give all information (except psychiatric treatment notes) to CUNA Mutual Life Insurance Society, MEMBERS Life Insurance Company ("Company") or its reinsurers to determine eligibility for benefits. Information obtained will be released only to reinsurers, the Medical Information Bureau, Inc., person performing business duties as delegated or contracted for by the Company related to my claim and subsequent insurance-related functions, as permitted or required by law, or as I further authorize. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

I agree this authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims and may be basis for denying this claim for benefits: and (4) I may receive a copy of this authorization.

For Residents of Vermont Only: This authorization does not include the disclosure of information concerning previously administered test for the HIV antibody, T-Cell Counts, AIDS or ARC.

For Residents of Maine Only: This authorization excludes disclosure of previously administered tests for the HIV antibody, however, does not limit the release of other information or notes related to an AIDS diagnosis.

Insured member's signature, legal guardian or authorized personal representative of the estate	**Date**	**Social Security Number**	**( ) Phone**

TO BE COMPLETED BY THE ATTENDING HEALTH CARE PROVIDER. PATIENT IS RESPONSIBLE FOR ANY CHARGES FOR COMPLETING FORMS.

History and Treatment

Patient name		Date of birth	Patient identification number
Primary diagnosis and/or concurrent conditions			"GAF" rating, if applicable
Date this disability began	Date you first treated patient for this condition	Hospitalization dates (if any)	Most recent date of treatment
Date symptoms first appeared	List name and phone number of **prior** or referring health care provider Name: Phone: **( )**		Is patient still under your care? ☐ Yes ☐ No If no, date released

Had patient received medical advice, diagnosis or treatment (including prescription medication) for this condition or a related condition before this episode? ☐ Yes ☐ No If yes, when?	Please list frequency of treatment in the **12 months prior** to the date of disability **to the present, including prescription medications.**
Was patient referred to another health Care provider or rehabilitation program? ☐ Yes ☐ No	If yes, please provide name and phone Name: Phone: ( )

Extent of Disability

Has patient been released to return to work? ☐ Yes ☐ No	If yes, dates released to: ☐ Regular Duty _____ ☐ Restricted: _____ Hours per day: Hours per week:	If no, estimated recovery date (Providing this date may eliminate frequent completion of this form):
If disabled until next appointment date, give appointment date:	Please list work restrictions, duration, or other remarks:	

What do you expect regarding this condition? ☐ Improvement ☐ No Change ☐ Deterioration ☐ Unknown

Pregnancy Information

Estimated or actual date of delivery:	Complications that prevented work **prior** to delivery: Date complications began: Date complications ended:
Type of delivery:	Complications that prevented work **after** delivery: Date complications began: Date complications ended:

Physician information

Physician Name:			Tax ID #:
Street:			Phone: ( )
City	State:	Zip	Fax: ( )
Person to contact if additional information is needed:			Contact person phone (if different from above) ( )
Physician signature:	**Degree**		**Today's date:**

CD1 Rev(04/06)