USAA®

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

# CONTINUING DISABILITY/HOSPITALIZATION BENEFIT VERIFICATION FORM

**Please see instructions on the reverse side of this benefit verification form.**

## A. CARDMEMBER INFORMATION (must be completed and signed below) — PLEASE PRINT

| NAME AND ADDRESS ☐ IF ADDRESS IS INCORRECT CHECK HERE AND ENTER CORRECTION ON BACK OF FORM | ACTIVATION NUMBER |
|---|---|
| | EMAIL ADDRESS (IF AVAILABLE) |
| | NAME OF CREDITOR |

## B. DISABLED/HOSPITALIZED PERSON'S INFORMATION — PLEASE PRINT

| NAME OF DISABLED/HOSPITALIZED PERSON | DISABLED/HOSPITALIZED PERSON IS ☐ Cardmember ☐ Joint Cardholder | |
|---|---|---|
| NAME OF EMPLOYER | TELEPHONE NUMBER (EMPLOYER) ( ) | EXTENSION |
| DESCRIBE CURRENT ACTIVITIES OR ANY CHANGE IN CONDITION | | |
| RETURNED TO WORK SINCE BECOMING DISABLED ☐ Yes ☐ No If yes, ☐ Full-Time ☐ Part-Time | DATE RETURNED TO WORK / / | # OF HOURS PER WEEK |
| APPLIED FOR SOCIAL SECURITY DISABILITY ☐ Yes ☐ No | ARE YOU RECEIVING SOCIAL SECURITY DISABILITY ☐ Yes ☐ No | **IF YES, ATTACH A COPY OF SOCIAL SECURITY AWARD LETTER OR VERIFICATION THAT SSDI IS BEING RECEIVED TO THIS FORM** |

**AUTHORIZATION:** 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 USAA Debt Protection Plan℠ Administrator or its representatives, 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.**

| CARDMEMBER OR JOINT CARDHOLDER SIGNATURE (REQUIRED) X | TELEPHONE NUMBER ( ) | DATE / / |
|---|---|---|

## C. PHYSICIAN STATEMENT (to be furnished without expense to American Bankers Management Company) — PLEASE PRINT

| PATIENT'S FULL NAME | PATIENT'S STREET ADDRESS/APT. # | CITY | STATE | ZIP CODE | AGE |
|---|---|---|---|---|---|
| | | | | | |

| OBJECTIVE DIAGNOSIS/FINDINGS | DIAGNOSIS CODE(S) ☐ ICD-9 _____ ☐ CPT _____ ☐ DSM III _____ |
|---|---|
| DATES OF TREATMENT FOR THE LAST 6 MONTHS | FREQUENCY OF VISITS ☐ Weekly ☐ Monthly ☐ Other _____ |

| IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION ☐ Yes ☐ No | IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK / / | IF NO, DATE PATIENT WAS RELEASED TO RESUME WORK / / |
|---|---|---|

| LIST LIMITATIONS |
|---|
| GIVE EXACT DATES OF DISABILITY (UNABLE TO WORK) FROM / / TO / / |

| **IS PATIENT PERMANENTLY DISABLED** ☐ Yes ☐ No | IF PATIENT IS TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED ☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined |
|---|---|

**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.**

| PHYSICIAN SIGNATURE X | PHYSICIAN'S NAME (PRINT NAME) | | | MEDICAL I.D. # | DATE / / |
|---|---|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( ) | FAX NUMBER ( ) |

**FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY PHYSICIAN'S OFFICE**

**A benefit verification form must be submitted with updated information every 30 days to be considered for continued benefits.**

**FAX, MAIL, OR UPLOAD COMPLETED FORM AND ANY ATTACHMENTS TO 305-259-4575 OR MAIL TO ADDRESS BELOW, OR ONLINE TO CARDBENEFITS.ASSURANT.COM.**

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

Dear Valued Cardmember:

Thank you for giving American Bankers Management Company the opportunity to assist you!

To be considered for continued benefit activation:
1. Complete Sections A and B.
2. Have physician complete Section C.

Please include activation number on all correspondence sent to our office. This will assure prompt and efficient handling of the information provided. Also, for faster service when calling, please have activation number ready. After 15 business days, the activation status may be verified through the automated inquiry system, Monday through Friday, 9:00 a.m. to 6:00 p.m., Eastern Time, by calling 1-800-859-0568.

| **NAME AND ADDRESS CORRECTION** | | **PLEASE PRINT** |
|---|---|---|
| NAME | | |
| STREET ADDRESS/APT. # | | |
| CITY | STATE | ZIP CODE |