Payment Protection Claims | P.O. Box 795027 | San Antonio, Texas 78279

PaymentProtectionClaims@swbc.com | Business Hours: 800.527.0066 Ext. 17205 | After Hours: 210.321.7205 | 210.525.1247

PAYMENT PROTECTION—FREQUENTLY ASKED QUESTIONS FOR *DISABILITY* BENEFITS

Quick tips

- Keep your Certificate of Insurance or Loan Addendum where it's easily accessible so in the event you need to file a claim, you'll know exactly what's covered and what's not covered.
- Verify you have coverage by contacting your lender before completing claim paperwork.
- Carefully read and complete all items within your claim packet. You may provide any supporting documentation that could have an impact on the determination of your claim:
  - Copies of medical records/Emergency room records
  - Workers' compensation paperwork/FMLA paperwork
  - Police report
  - Proof of self-employment
- Claims are reviewed in order as they come in.
- In order to expedite your call, please have your claim number, lender name, contact name, and all questions written down.
- All benefit payments are issued to the financial institution; please allow 3–7 business days for processing. If not received, contact your financial institution first to confirm.

Q: How long is my waiting period?

A: Depending on your lender's specific program, the waiting period may be non-retroactive or retroactive for 7, 14, or 30 days. Waiting period means the consecutive number of days that you are unable to work before benefits would begin. Do not complete or submit your claim until the waiting period has been met.

Q: How should this initial claim be completed?

A: Part 2—Borrower's statement is completed by the covered borrower filing the claim.

Part 3—Employer's statement is completed only by your current, or most recent, employer.

Part 4—Doctor's statement is completed only by a licensed physician that has provided medical care and can attest to the disabling condition.

Q: What is the process for my claim review and how long should I expect it to take?

A: This varies depending on multiple claim processes:

Claim set up (all documentation must be completed and received by SWBC from claimant and financial institution).

Individual policy and claim must be reviewed by Claims Examiner and/or a Medical Director (additional documentation and/ or medical records may be needed; medical record turnaround time depends on each facility).

Final eligibility review.

Q: Why is eligibility reviewed at claim time and not when I apply?

A: Because the certificate of insurance or loan addendum is issued by your lender at loan closing. As such, eligibility is reviewed once an initial claim is received by SWBC.

Q: When are the policy provisions explained?

A: A complete explanation is provided to the borrower(s) by your loan representative and is also in your Certificate of Insurance (if Credit Insurance) or Loan Addendum (if Debt Cancellation Protection) when coverage is elected. Your coverage is subject to the terms and conditions in your policy. Please read your forms carefully for a full explanation of the terms and conditions, a complete description of your coverage, and any specific eligibility requirements, limitations, or exclusions. Should you have any questions you may call 800.527.0066 Ext. 17205.

Q: Are payments made on my loan due date or at another time?

A: Total disability benefits begin after the waiting period has been met at the time you became disabled. If total disability continues, benefits are paid for each subsequent thirty (30) day periods. If less than 30 days, benefits equal 1/30th of a monthly benefit for each day of total disability and are paid accordingly.

Q: How often are continuing claim forms required?

A: Written proof of continuing total disability is required to pay a monthly benefit. Therefore, claim forms may be required on a monthly basis.

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INSTRUCTIONS: REQUEST FOR *DISABILITY* BENEFITS

These forms must be completed after the waiting period* has been satisfied.

(*If unsure of your waiting period, contact your lender)

INITIAL DISABILITY PACKET PAGES 1 THROUGH 7

Please return these forms in a timely manner and keep a copy for your records.

If possible, original completed forms should be sent in by mail.

Review complete packet and complete as required

Part 1: Loan Information

Part 2: Borrower Information

This section should be fully completed, by the borrower, signed and dated.

HIPAA/Authorizations for Uses and Disclosures of Medical Information Form(s)

Print your name, date of birth, Social Security Number and sign and date where noted, returning to us along with the completed disability form.

Part 3: Employer Information

This section must be fully completed, signed and dated by your current or previous employer.

Notice:

If you are self-employed, you may complete this section and, if additional information is required, you will be notified via a detailed letter outlining what is needed.

Part 4: Doctor Information

This section must be fully completed, signed and dated by a licensed Physician and/or Doctor who is providing you medical care and will attest that your condition has caused you to be Totally Disabled.

In order to review your request for benefit payments, your Total Disability must be certified by a licensed physician.

INCOMPLETE INFORMATION MAY CAUSE A DELAY IN CONSIDERING YOUR REQUEST

Important Information

- Additional Investigation. Your request for benefits may require further investigation. You will be notified if additional time is needed to consider your claim for payment.
- You are responsible for making any scheduled loan payments that become due during the time we are reviewing your claim.
- You are responsible for any outstanding balance that may not be covered by your monthly disability benefit. Your plan does not cover late charges, fees, or penalties. Please continue to make your loan payments in a timely manner until benefits begin to avoid any late charges or additional fees.
- By providing your email address, you consent to be contacted by an SWBC representative via email.

These forms are being sent to you in anticipation of you filing a Benefit Request. We will not begin processing your request until all necessary completed forms and document(s) are received. If these forms are not completed and returned within 30 days of being mailed to you, we will assume you no longer wish to file a request.

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WARNING: Any person who knowingly submits a request for benefits containing a false or deceptive statement is guilty of fraud and may be subject to criminal penalties.

INITIAL DISABILITY FORM

Incomplete Information May Cause A Delay In Considering Your Request

PART 1 | FINANCIAL INSTITUTION—LOAN/LINE OF CREDIT (LOC) INFORMATION

Lender Name: _____ **Loan Account Number(s):** _____

We suggest that you keep in contact with your Financial Institution and make sure your loan account remains current.

PART 2 | BORROWER'S STATEMENT—YOU COMPLETE THIS PART

Name: _____

Social Security Number: _____ **Date of Birth:** _____

Address: _____

City, State, Zip: _____

Phone Number: _____ **Email Address:** _____

1. Describe your cause of disability: _____

If your disability was an accident, when did it occur and how?

_____

_____

2. How long have you been, or will you be, off work due to this disability?

Beginning: _____ to: _____ (Actual or Estimated)

3. First treatment for this condition or similar condition? _____

4. Are you self-employed? ☐ **Yes** ☐ **No**

5. What was your occupation at the time of your disability? _____

6. Are you receiving Social Security Disability benefits? ☐ **Yes** ☐ **No**

Please include copy of benefit statement.

7. Please list the name and addresses of all doctors who have treated you for any condition(s) in the past two (2) years on the separate sheet provided, (page 3). Please include your primary care physician.

I understand any false statement made knowingly and willfully to obtain information from federal records is punishable by fine, imprisonment or both.

Sign and return to: SWBC, ATTN: Payment Protection Claims, PO Box 795027, San Antonio, TX 78279-5027; or

Email to: PaymentProtectionClaims@swbc.com

Borrower/Claimant Name: (Print) _____

Signature: _____ **Date:** _____

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SOUTHWEST BUSINESS CORPORATION (SWBC)

Administer for: _____

(FOR SWBC USE ONLY)

AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL INFORMATION

This Authorization is designed to comply with the HIPPA Privacy Rule.

To the borrower/claimant: During your claim, and as a part of the claim proof requirements of your policy, Southwest Business Corporation ("SWBC") will need information to determine your eligibility for benefits. All information we obtain with this authorization will be kept confidential. Any alteration to or limitation of this authorization will prejudice SWBC's right to independently evaluate your claim and may prevent benefits from being provided.

I AUTHORIZE THESE PERSONS OR ENTITIES HAVING ANY KNOWLEDGE OF MY HEALTH OR ME:

Physician, therapist, healer or medical practitioner, hospital, clinic, pharmacy, or other medically related facility or association* other health care provider* insurance company or insurance support organization* employer, business associate, group health plan, or administrator* law enforcement agency* social security administration* agency, organization or entity administering a benefits program* medical record retrieval services* educational, vocational or rehabilitation organization, financial institution, bank, accountant, tax preparer, attorney* or other persons or institutions.

TO PROVIDE THE FOLLOWING INFORMATION TO SWBC OR ITS AUTHORIZED REPRESENTATIVES:

- My complete patient file and entire medical record including any charts, notes, x-rays, operative reports, lab and medication records, copies of all prescriptions, and all other medical information about me including my medical history, diagnosis, testing and test results, consultation reports, prognosis and treatment of any physical condition, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, communicable disease or disorders, sexually transmitted disease, mental, psychiatric or psychological condition including test results; drug, alcohol, or other substance abuse including treatment or therapy.
- Non-medical information about me, including information concerning my education, occupation, employment history, earnings, finances, unemployment benefits, applications for insurance, or eligibility for other benefits
- Social Security information concerning me, including detailed information regarding earnings for up to ten (10) years, and/or a summary record of total earnings, and/or information from master benefits records regarding the award, denial, or continuation of benefits.

I UNDERSTAND, ACKNOWLEDGE AND AGREE TO THE FOLLOWING PROVISIONS:

No Restrictions: Any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct the persons or organizations identified in paragraph two (2) above to release and disclose my entire medical record without restriction. **Purpose:** SWBC will use the information to (1) properly evaluate my claim and determine my eligibility for coverage; and (2) conduct other legally permissible activities. **Use:** In the course of conducting its business, SWBC may disclose to other parties information about me. SWBC may release this information about me to affiliates, reinsurers, and any person performing business or legal services for SWBC. The information disclosed pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule and may be redisclosed pursuant to this Authorization or otherwise as permitted or required by law. **Right to Revoke:** I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by the SWBC in reliance on this Authorization, by sending a written revocation to: SWBC, PO Box 79502, San Antonio, Texas 78279-5027. **Expiration:** This Authorization will remain in effect for a maximum of 12 months from the date of signature below. **Copy:** My authorized representative or I have a right to receive a copy of this Authorization. A photocopy or facsimile of this Authorization is as valid as the original. I understand that if I refuse to sign this Authorization to release my complete medical records, SWBC may not be able to evaluate my claim and it may prevent benefits from being provided.

I understand any false statement made knowingly and willfully to obtain information from federal records is punishable by fine, imprisonment or both.

Sign and return to: SWBC, ATTN: Payment Protection Claims, PO Box 795027, San Antonio, TX 78279-5027; or

Email to: PaymentProtectionClaims@swbc.com

Borrower/Claimant Name: (Print) _____

Date of Birth: _____ **Social Security Number:** _____

Signature: _____ **Date:** _____

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LIST OF PHYSICIANS, HOSPITALS, AND PHARMACIES:

Please provide the names, addresses, phone numbers, and dates of service for all of the physicians, hospitals, and pharmacies, which provided treatment for the Insured within the past five (5) years. Failure to do so may cause a delay in processing the claim. Please use the back of this form for any additional provider or pharmacy information.

Borrower's Name: (Please Print) _____

PLEASE PRINT ACCURATELY AND CLEARLY—SIGN AND DATE AT THE BOTTOM

(If physicians are in the same clinic/facility, please list all names under the same address)

1. Group/Physician/Pharmacy Name: _____
   Specialty: _____
   Address: _____
   Telephone Number: _____
   Fax Number: _____
   Dates of Treatment: from: _____ to: _____

2. Group/Physician/Pharmacy Name: _____
   Specialty: _____
   Address: _____
   Telephone Number: _____
   Fax Number: _____
   Dates of Treatment: from: _____ to: _____

3. Group/Physician/Pharmacy Name: _____
   Specialty: _____
   Address: _____
   Telephone Number: _____
   Fax Number: _____
   Dates of Treatment: from: _____ to: _____

4. Group/Physician/Pharmacy Name: _____
   Specialty: _____
   Address: _____
   Telephone Number: _____
   Fax Number: _____
   Dates of Treatment: from: _____ to: _____

Sign and return to: SWBC, ATTN: Payment Protection Claims, PO Box 795027, San Antonio, TX 78279-5027; or

Email to: PaymentProtectionClaims@swbc.com

Borrower/Claimant Name: (Print) _____

Signature: _____ **Date:** _____

Name of Lender: _____

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INITIAL DISABILITY FORM

B. EMPLOYER'S STATEMENT—CURRENT OR PREVIOUS EMPLOYER COMPLETES THIS PART

Borrower's Name: (Please Print) _____

Name of Employer: _____

Employer's Address: _____

City, State, Zip: _____

Phone Number: _____ **Email Address:** _____

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1. How long was employee off work due to their disability? From: _____ **to:** _____

2. Date employee returned to work? _____

a. Do you have ANY light duty work available? ☐ Yes ☐ No

3. Is the current disability a work related injury? ☐ **Yes** ☐ **No** **Date of injury:** _____

a. If yes, please provide the worker's compensation (W/C) information:

W/C Carrier Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

4. List dates of any other absences caused by illness or injury during the past 12 months:

Date Range	Reason	Date Range	Reason

5. What is the employee's job title? _____

a. Date Employed: _____

b. Type of Employment: ☐ Full-Time ☐ Part-Time ☐ Seasonal, average hours worked per week: _____

c. What are the employee's principal job duties?

☐ Laborer Technical ☐ Management ☐ Semi-skilled ☐ Clerical ☐ Professional ☐ Skilled ☐ Supervisory ☐ Executive

d. Briefly describe usual duties: _____

Remarks: _____

_____

Your Name and Official Position: (Please Print) _____

Employer's Signature: (Required) _____ **Date: (Required)** _____

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Borrower's Name: _____

Address: _____ **City, State, Zip:** _____

Phone Number: _____ **Email Address:** _____

PART 4 | DOCTOR'S STATEMENT—TREATING DOCTOR COMPLETES THIS PART

1. Primary disabling diagnosis: _____

a. Specify other conditions/complications affecting total disability: _____

b. When was this condition or conditions first diagnosed? _____

2. If disability was the result of an injury, please describe how it occurred? _____

3. Is disability due to a pregnancy? ☐ **Yes** ☐ **No** **LMP Date:** _____

If yes, are there any unusual complications? Please describe. _____

4. Is disability due to alcohol, drugs or drug related? ☐ **Yes** ☐ **No**

5. When did symptoms first appear or accident happen? _____

6. When did patient first consult you for this disabling condition? _____

a. Is patient still under your care? ☐ Yes ☐ No

b. Have you ever treated the patient for this condition or a similar condition before? ☐ Yes ☐ No

DEFINITION OF TOTAL DISABILITY is defined as sickness or injury in which the insured is prevented from performing the essential duties of their occupation prior to such disability. Provide Patient's Occupation: _____

7. Date patient first unable to work because of disabling condition: _____

a. Is (or was) patient totally disabled? (See definition above) ☐ Yes ☐ No (Answer required)

8. When was (or would) patient be able to return to full-time work? _____ **to part-time work?** _____

9. List restrictions or limitations: _____

a. How long are these limitations in effect? _____

10. If patient hospitalized, give name and address of hospital:

a. Date Admitted: _____ Hospital Name: _____

b. Date Discharged: _____ Street Address: _____

c. Describe Surgical Procedure: _____ City, State, Zip: _____

11. Provide all dates of treatment/surgery for this disabling condition 6 months prior to the date disability began to the present:

Month/Day/Year	Procedure/Treatment	Month/Day/Year	Procedure/Treatment

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Borrower's Name: _____

Address: _____ **City, State, Zip:** _____

Phone Number: _____ **Email Address:** _____

PART 4 | DOCTOR'S STATEMENT—TREATING DOCTOR COMPLETES THIS PART (CONT.)

12. If monthly treatment is not rendered, how often does the patient require treatment? _____

Please explain: _____

13. If you have referred the patient to another doctor(s) for consultation or treatment, list names and addresses:

_____

_____

14. Remarks: _____

_____

_____

15. Doctor's Name: (Please print) _____ **Phone:** _____

Address: _____

City, State, Zip: _____

Doctor's Signature (Required)	Date (Required)	NPI Number

I hereby attest that the above information is true and accurate to the best of my knowledge.

Sign and return to: SWBC, ATTN: Payment Protection Claims, PO Box 795027, San Antonio, TX 78279-5027; or

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