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 *LIFE* BENEFIT

Quick tips

- Keep your Certificate of Insurance or Loan Addendum where it is easily accessible so in the event you need to file a claim, you'll then know exactly what's covered and what's not covered.
- Verify active coverage with the lender before completing any claim paperwork.
- Carefully read and complete all items within the claim packet. You may provide any additional supporting documentation that could have an impact on the determination of the claim.
- Examples:
  - Letters of administration/testamentary
  - Executor of estate documentation
  - Power of attorney documentation
  - Probate court documentation
  - Photo copy of your driver's license
  - Copy of the deceased's marriage certificate (if applicable)
- Claims are reviewed in order based on the date and time documentation is received in our office.
- In order to expedite a call, please have your claim number, lender name, claims contact name (if applicable), and all questions written down.
- If benefits are paid to the financial institution, allow 3–7 business days for processing. Contact the financial institution first to see if they have received a payment before reaching out to our office.

Q: How long will the claim review process take? How does it work?

A: This varies depending on multiple claim processes:

1. Claim set up (all documentation must be completed appropriately and received from the next of kin and financial institution)
2. The individual's policy and claim must be reviewed by the claims examiner and/or medical director/third party administrator (additional documentation and/or medical records may be needed; medical record turnaround time depends on each facility)
3. If necessary, a final eligibility review will be conducted

Q: Why is eligibility reviewed at claim time and not when the individual applies for coverage?

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 has been received by SWBC.

Q: When are the policy provisions explained to the covered borrower?

A: A complete explanation of policy provisions is provided by the loan representative and is also in the individual's Certificate of Insurance (if Credit Insurance) or Loan Addendum (if Debt Cancellation Protection) when coverage is elected. Coverage is subject to the terms and conditions in this policy. Please read all forms carefully for a full explanation of the terms and conditions, a complete description of the coverage, and any specific eligibility requirements, limitations, or exclusions. Should any questions arise, please call **800.527.0066 Ext. 17205.**

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INSTRUCTIONS: REQUEST FOR LIFE BENEFIT

LIFE PACKET PAGES 1 THROUGH 3

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

Review full packet and complete as required

Part 1—Provide Loan Information

Part 2—Sections A, B, C and D. Borrower/Deceased's Information:

These sections should be fully completed in writing, signed, and dated by the authorized representative of the estate or next of kin.

HIPAA/Authorizations for Uses and Disclosures of Medical Information Form

This form must be completed in writing, signed, and dated by the authorized representative of the estate or next of kin. Print the deceased's name, date of birth, and social security number at the bottom of the page. Sign and print your name, then indicate your relationship to the borrower/deceased and date. Please return this authorization form to us with Part 1 and 2.

Please attach the following documents.

- A certified copy of the death certificate indicating the cause of death.
- If applicable, the court documents appointing you the authorized representative of the estate.

INCOMPLETE INFORMATION MAY CAUSE A DELAY IN CONSIDERING YOUR REQUEST

Important Information

- Please be sure to provide the lender's name and loan number.
- Loan extensions or loan advances PRIOR to the date of death may not be covered. Loan extensions or loan advances added AFTER the date of death are not covered.
- Scheduled loan payments that become due during the time we are reviewing this claim must be paid as required by the lender.
- This claim may require further investigation. If so, we will need additional time to obtain and review this information. If this occurs, you will be notified.
- By providing your email address, you consent to be contacted by a SWBC representative via email.

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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.

NOTICE OF DEATH CLAIM

To be completed, signed, and dated by the authorized representative of the estate or next of kin and include court documents appointing you the Authorized representative of the estate, if applicable. Print answers to all questions—incomplete forms can result in a delay

INCOMPLETE INFORMATION MAY CAUSE A DELAY IN CONSIDERING YOUR REQUEST

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

Lender Name: _____ **Loan Number:** _____

We suggest that you keep in contact with the lender and make sure the loan account remains current.

PART 2 | DECEASED BORROWER INFORMATION

A. Name: _____ **SSN:** _____

Address (street, city, state,zip: _____

Date of Birth: _____ **Date of Death:** _____

B. Name, address, and telephone number of the primary care physician (PCP):

_____

_____

C. Name, address, and telephone number of ALL other physicians who treated the deceased borrower three (3) years prior to the Loan Effective Date of _____ **(use the back or separate sheet if necessary)**

_____

_____

_____

Name, address, and telephone number of last employer:

_____

_____

Provide date last worked: _____

Name of healthcare insurance provider, address, telephone number, policy number:

_____

_____

Name of Pharmacy, address, telephone:

_____

_____

Deceased Borrower's Name: (Please Print)

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PART 2 | DECEASED BORROWER INFORMATION (CONT.)

D. The statements above are true and complete. I/we agree that the Company may rely upon them as part of the proofs of death under the policy number. Any physician who has attended (Deceased Insured), and/or any hospital (including Veteran's Administration Hospital) or other institution in which the Deceased Insured was treated or confined, is hereby authorized to furnish or its representatives, SWBC, any and all information and records with respect to any illness or injury, medical history, consultations, prescriptions, or treatment pertaining to the Deceased Insured. Such information may be included as part of the proof of death submitted to the Company. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that as next-of-kin I may request a copy of this authorization. This authorization shall be valid for the duration of the claim.

Signature of Authorized Representative of the Estate or Next-of-Kin

Date

Print Name of Authorized Representative of the Estate or Next-of-Kin

Relationship to Borrower/Deceased

Authorized Representative of the Estate or Next-of-Kin Mailing Address

Telephone Number (include area code)

Email

By providing your email address, you consent to be contacted by a SWBC representative via email.

Deceased Borrower's Name: (Please Print) _____

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

I AUTHORIZE THESE PERSONS OR ENTITIES HAVING ANY KNOWLEDGE OF THE BORROWERS HEALTH:

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:

- The borrowers 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 the borrower including their 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 the borrower, including information concerning education, occupation, employment history, earnings, finances, unemployment benefits, applications for insurance, or eligibility for other benefits
- Social Security information concerning the borrower, 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 the borrowers 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 the borrowers entire medical record without restriction. **Purpose:** SWBC will use the information to (1) properly evaluate my claim and determine 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 the company. 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 SWBC in reliance on this Authorization, by sending a written revocation to: SWBC, PO Box 795027, 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: The authorized representative has 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 the borrowers complete medical records, SWBC may not be able to evaluate this 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 PaymentProtectionClaims@swbc.com

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

Authorized Representative's Name: _____

Signature: _____ **Date:** _____