CREDIT LIFE / TERMINAL ILLNESS / DISMEMBERMENT CLAIM FORM

W.S. BADCOCK CORPORATION

Customer Insurance Department • P.O. Box 497, Mulberry, FL 33860 • Phone: (844) 556-9262 • Fax: (863) 869-7964

STORE CODE: _____ **Date of Loss:** _____ / _____ / _____

Account Balance as of the Date of Loss: _____

Number of Months Delinquent: _____

TO AVOID DELAY IN PROCESSING, PLEASE ATTACH:

1. Certified Copy of the Death certificate (for Life claim only).
2. Copy of the deceased's monthly charge account billing statement showing the account balance on the Date of Death (for Life claim only).
3. **Terminal Illness or Dismemberment claims (Florida and Alabama only) have Physician complete Physician's Statement, Section B.**
4. Sign Section C and D.
5. Return this claim form and any documentation to your local Badcock store or to the address above.

SECTION A: ACCOUNT HOLDER INFORMATION. Please Print or Type the Answers to All Questions.

_____ _____ / _____ / _____ _____ / _____ / _____

Account Number Ins. Code Date of Birth Year-to-Date

_____ _____

Account Holder's Name (or Name of Deceased) Social Security Number

_____ _____

Account Holder's Street Address City / State / Zip

_____

Account Holder's Spouse/Name of Co-Account Holder

Certified as Complete and Correct by:

_____ _____ / _____ / _____

Authorized W.S.Badcock Corporation Representative Date

SECTION B: ATTENDING PHYSICIAN'S STATEMENT

To be completed by your Physician for TERMINAL ILLNESS Requests Only. Terminal Illness Coverage Sold Only in Florida and Alabama.

I hereby certify _____ is terminally ill and has less than 12 months to live. The diagnosis of _____ was made on _____. The patient was last treated _____.

Physician's Name: _____ Telephone Number: _____

Street Address: _____ City/State/Zip:_____

Physician's Signature: _____ Date:___/___/___ Tax ID Number _____

To be completed by your Physician for DISMEMBERMENT Only. Dismemberment Coverage Sold Only in Florida and Alabama.

_____ _____ _____

Patient's Name Diagnosis **ICD9 Code Required**

(a) When did accident occur? Mo. _____ Day _____, Year _____

(b) Date of first visit for this condition: Mo. _____ Day _____, Year _____

(c) Date loss occurred: Mo. _____ Day _____, Year _____

Type of loss suffered - please check all that apply:

☐ one or both feet at or above the ankle joint
☐ one or both hands at or above the wrist joint
☐ the entire sight in one or both eyes

_____ ____/____/____

Physician's Name (Please Print) Date

_____ _____ _____

Physician's Address City / State / Zip Telephone Number

_____ ____/____/____ _____

Physician's Signature Date Tax ID Number

SECTION C. AUTHORIZATION: (To Be Completed by Claimant)

AUTHORIZATION: Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide my credit insurance company or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the Insured named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide my insurance company with financial or employment-related information.

I understand that such information will be used by the insurance company for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the term of the policy.

I hereby certify that I have read and understand the attached Fraud Warning Statement.

Date _____ /_____ /_____ Signature of Claimant _____

SECTION D: HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Records and information obtained will be disclosed to my Insurance Company and the Authorized Program Administrator. The purpose of this disclosure is to evaluate my application to activate benefits. I hereby authorize for you to release any and all records and information within your possession, custody and control pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my/their physical or mental condition are to be released. Such records and information to be released may include but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescription, HIV testing and treatment, STD testing and treatment. Genetic testing, Sickle Cell testing and treatment. Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, record custodians, or anyone else to release any and all records and information regarding:

Patient's Name: _____

Other Names Used: _____

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

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the program administrator any may no longer be protected by the same rule that applied in the first instance. This Authorization will remain if effect a maximum of (12) twelve months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of the program administrator in writing to: P.O. Box 45153, Jacksonville, Florida 32232-5153, unless action has already been taken in reliance upon it. A photocopy of this Authorization will be treated in the same manner as the original.

Date: ____ /____ /____ **Signature of Patient/Guardian/Personal Representative**: _____

Legal relationship to applicant: _____
(Only if signed above by guardian or personal representative)

STATE SPECIFIC FRAUD WARNINGS

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under this title.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas and New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

District of Columbia and Washington DC Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Tennessee and Virginia Residents: 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 a denial of insurance benefits.

Maine Residents: 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 benefits.

Minnesota Residents: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact may be guilty of an insurance fraud, which is a crime, and may be subject to prosecution.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Texas, West Virginia and Alabama Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison, or any combination thereof.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

DETACH AND PROVIDE TO CUSTOMER