USAA®

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

ACTIVATION NUMBER (FOR INTERNAL USE ONLY)

BENEFIT VERIFICATION FORM

INSTRUCTIONS: Find the type of occurrence below. Please make sure the required sections are completed in full and that any required documents are attached. An incomplete form will be returned, delaying the processing of your benefit Activation.

DISABILITY AND HOSPITALIZATION

If Primary Cardmember (as described in your Amendment to Cardmember Agreement) **is disabled:**

1. Complete and sign Sections 1 and 2.
   - **If receiving Social Security Disability (SSDI), please provide us with a copy of the award letter or verification of SSDI.**
2. Have **employer** at the time of occurrence complete Section 3 (**disregard employment verification if retired**).
   - If **self-employed** – Complete **Section 3** and attach **a copy of business license or bankruptcy papers.**
3. Have the **treating physician** complete Section 4.
4. **Attach a recent copy of your ENTIRE CREDIT CARD BILLING STATEMENT.**

UNEMPLOYMENT

If Primary Cardmember (as described in your Amendment to Cardmember Agreement) **is unemployed:**

1. Complete and sign Sections 1 and 2.
2. Have **employer** at the time of occurrence complete Section 3 (**disregard employment verification if retired**).
3. Attach a copy of state Unemployment or strike benefit check(s) or Registration Card or letter from a recognized Employment Agency or Job Service for all months unemployed.
4. **Attach a recent copy of your ENTIRE CREDIT CARD BILLING STATEMENT.**

FAMILY LEAVE

If Primary Cardmember (as described in the Amendment to Cardmember Agreement) **is permitted an unpaid leave:**

1. Complete and sign Sections 1 and 2.
2. Have **employer** at the time of occurrence complete Section 3 (**disregard employment verification if retired**).
3. **Attach a recent copy of your ENTIRE CREDIT CARD BILLING STATEMENT.**

SERVICE ACTIVATION

If Primary Cardmember is called to active US military duty:

1. Complete Section 1.
2. Have **your employer** at the time of your event complete Section 2.
3. Attach a copy of **your official military orders**.
4. **Attach a copy of your ENTIRE CREDIT CARD BILLING STATEMENT for the month in which your leave started.**

UNFORESEEN DEATH

If Primary Cardmember (as described in the Amendment to Cardmember Agreement) **dies:**

1. Complete and sign Sections 1 and 2.
2. Attach a certified copy of the death certificate.
3. **Attach a recent copy of your ENTIRE CREDIT CARD BILLING STATEMENT.**

SECTION 1 - CARDMEMBER INFORMATION

PLEASE PRINT

NAME OF CREDITOR	CREDIT CARD - ACCOUNT NUMBER	ACTIVATION NUMBER (Internal use only)

NAME OF CARDMEMBER	TELEPHONE NUMBER (DAY) ( )	TELEPHONE NUMBER (EVENING) ( )

STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE	YOUR INTERNET ADDRESS (IF AVAILABLE)

SECTION 2 - AFFECTED PERSON INFORMATION

PLEASE PRINT

NAME	AFFECTED PERSON IS ☐ Cardmember ☐ Joint Cardholder

STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER (DAY) ( )	TELEPHONE NUMBER (EVENING) ( )

DATE OF OCCURRENCE / /	TYPE OF OCCURRENCE ☐ Unforeseen Death ☐ Disability ☐ Unemployed ☐ Unpaid Family Leave	IF UNEMPLOYED, DO YOU QUALIFY FOR UNEMPLOYMENT BENEFITS ☐ Yes ☐ No

PLACE OF EMPLOYMENT (NOT REQUIRED IF RETIRED OR SELF-EMPLOYED)

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 American Bankers Management Company or its representatives as requested, 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 SIGNATURE (REQUIRED)	SOCIAL SECURITY NUMBER	DATE
X	- -	/ /

SECTION 3 - EMPLOYER STATEMENT

PLEASE PRINT

TO BE COMPLETED BY YOUR EMPLOYER OR UNION REPRESENTATIVE

EMPLOYEE'S NAME	DATE HIRED	NUMBER OF HOURS WORKED PER WEEK
	/ /	

REASON FOR INTERRUPTION OF EMPLOYMENT

☐ Laid Off ☐ Terminated ☐ Assignment Ended ☐ Military Duty ☐ Other _____

☐ Quit ☐ Resigned ☐ Disability ☐ Unpaid Family Leave

PLEASE EXPLAIN REASON FOR INTERRUPTION OF EMPLOYMENT OR FAMILY LEAVE

IF INTERRUPTION WAS THE RESULT OF FAMILY LEAVE, WAS LEAVE APPROVED	WILL EMPLOYEE RECEIVE COMPENSATION DURING THE LEAVE	IF YES, GIVE DATES OF COMPENSATION
☐ Yes ☐ No	☐ Yes ☐ No	FROM / / TO / /

LAST DAY WORKED	DATE RETURNED TO WORK	TYPE OF EMPLOYMENT
/ /	/ /	☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Temporary ☐ Self-Employed

NAME OF COMPANY	TELEPHONE NUMBER	EXTENSION	FAX NUMBER
	( )		( )

STREET ADDRESS	CITY	STATE	ZIP CODE

COMPLETED BY (PRINT NAME)	SIGNATURE	TITLE	DATE
	X		/ /

SECTION 4 - PHYSICIAN STATEMENT

PLEASE PRINT

TO BE FURNISHED WITHOUT EXPENSE TO AMERICAN BANKERS MANAGEMENT COMPANY

PATIENT'S FULL NAME	DIAGNOSIS CODE(S)
	☐ ICD-9 _____ ☐ CPT _____ ☐ DSM III _____

PATIENT'S STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE

OBJECTIVE DIAGNOSIS/FINDINGS

HAS PATIENT BEEN HOSPITALIZED	NAME OF HOSPITAL
☐ Yes ☐ No FROM / / THROUGH / /	

HOSPITAL STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

GIVE ALL DATES OF TREATMENT SINCE ONSET OF CONDITION

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION	IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK	IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK
☐ Yes ☐ No	/ /	/ /

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)	GIVE EXACT DATES OF PARTIAL DISABILITY
FROM / / TO / /	FROM / / TO / /

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT	IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED
☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled	☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)

☐ Class 1 - No limitation of functional capacity; capable of heavy work; No restrictions. (0-10%)
☐ Class 2 - Medium manual activity. (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

Remarks:

PROGNOSIS/COMMENTS

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'S NAME (PRINT NAME)	PHYSICIAN'S SIGNATURE	DEGREE	MEDICAL I.D. NUMBER	DATE
	X			/ /

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER	FAX NUMBER
				( )	( )

Form must be fully completed and signed or stamped by Physician's office.

When all required sections are complete, fax completed form and any attachments to 305-259-4575 or mail to:

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

After 15 business days, the activation status may be verified through the automated inquiry system, Monday - Friday, 8:00 a.m. - 8:00 p.m., Eastern Time by calling (800) 859-0568 .