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

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.

	documents are attached. An						one monvacioni		
		DISABILIT	Y AND H	OSPITALIZAT	TION				
If Primar	ry Cardmember (as describe	ed in your Amendme	nt to Card	dmember Aare	ement) is dis	abled:			
1.	Complete and sign Sections			3	· · · · · · · · · · · · · · · · · · ·				
	- If receiving Social Security Disability (SSDI), please provide us with a copy of the award letter or								
2	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.				ш оору о. ж		o or barra aproy	paporo		
4.	Have the treating physician complete Section 4. Attach a recent copy of your ENTIRE CREDIT CARD BILLING STATEMENT.								
	, , ,		NEMPLO						
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 Ur								
0.	Employment Agency or Job				i riogiotiation	ourd or lotter i	Tom a rooogmzou		
4.	Attach a recent copy of ye				TEMENT.				
			FAMILY						
If Primar	ry Cardmember (as describe		SEC YOU ASSUMPTION TO DESCRIPT TO	CAN SOLDEN WEST	ement) is pern	nitted an unpaid	leave:		
1.	Complete and sign Sections				, -				
2.	Have employer at the time		olete Sect	ion 3 (disrea	ard employme	ent verification if	retired).		
3.	Attach a recent copy of you								
				TIVATION					
If Primar	ry Cardmember is called to								
1.	Complete Section 1.	SOURCE DOCUME TON HAM SOUR SCHOOL DESIGNATION TO	sareareage etc.						
2.	Have your employer at the	e time of your event	complete	Section 2.					
3.	Attach a copy of your offic		III						
4.	Attach a copy of your EN		D BILLIN	G STATEME	NT for the mo	nth in which you	ır leave started.		
				N DEATH		, , , , , , , , , , , , , , , , , , , ,			
If Primary Cardmember (as described in the Amendment to Cardmember Agreement) dies:									
	Complete and sign Sections		i io Carui	nember Agree	omenty alooi				
1.	Complete and sign Sections Attach a certified copy of the	s 1 and 2.	t to Cardi	nember Agree	monty alour				
	Attach a certified copy of the	s 1 and 2. e death certificate.		_	*				
1. 2.		s 1 and 2. e death certificate.	IT CARD	BILLING STA	TEMENT.		PLEASE PRINT		
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		SECTION	3 - EM	PLOYER S	TAT	EMEN	VT.			PLEAS	EPRINT
TO BE COMPLETED BY YOUR EMPLOYER OR UNION REPRESENTATIVE											
EMPLOYEE'S NAME				<u></u>		E HIREC	1	NU	MBER OF HOU	RS WORKED PE	R WEEK
REASON FOR INTERRUPTI ☐ Laid Off ☐ Quit	☐ Terminated	☐ Assignment End	led	☐ Military D	3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Leave	□ Oth	er			_
PLEASE EXPLAIN REASON FOR INTERRUPTION OF EMPLOYMENT OR FAMILY LEAVE											
IF INTERRUPTION WAS TH LEAVE, WAS LEAVE APPRO ☐ Yes		ALL EMPLOYEE RECEUTIONS THE LEAVE	EIVE CON	MPENSATION	922	ERRINGA PO	IVE DATE	ES OF COMP		1	1
LAST DAY WORKED	DATE RETURNED TO WO	Television Contracts	PLOYME	1.00 miles	Į F	ROM	1		то	,	,
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TO BE FURNISHED	WITHOUT EXPEN		AC 102 103.0		1015(1015)		MATERIAL STREET	OMPANY	r ·		
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PATIENT'S STREET ADDRE	SS/APT. #			CITY			Ц Ю		STATE	ZP CODE	
OBJECTIVE DIAGNOSISÆI	NDINGS		.1							J	
HAS PATIENT BEEN HOSPITAL ☐ Yes ☐ No FROM / / THROUGH / /											
HOSPITAL STREET ADDRE	SS	C	YTI				STATE	ZIP CODE	E TELEP	HONE NUMBER	
GIVE ALL DATES OF TREAT	TMENT SINCE ONSET OF C	CONDITION					2		<u>", "</u>	,	
IS PATIENT STILL UNDER YOUR CARE FOR THIS IF PATIENT IS STILL UNDER YOUR CARE, GIVE EST CONDITION WHEN PATIENT WILL RESUME WORK								DATE PATIENT V			
☐ Yes	□No			/	1				ĺ	1 1	
GIVE EXACT DATES OF TO	TAL DISABILITY (UNABLE TO	TO WORK)	1	GIVE E		DATES (OF PARTI /	AL DISABILIT	TO	1 1	
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	Control Control	PHYSICIAN'S SI				DEGI			. I.D. NUMBER	DATE /	1
STREET ADDRESS		CITY	ST	ATE	ZIP	CODE	TE (LEPHONE N	UMBER	FAX NUMBER	3
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 .