CONTINUING DISABILITY BENEFIT VERIFICATION FORM

USAA Federal Savings Bank, C/O USAA Debt Protection - Plan Administrator, P.O. Box 977122 Miami, Florida 33197-7122

LOAN NUMBER

Please see instructions on the reverse side of this benefit verification form.

A. COVERED PERSON'S INFORMATION (must be completed and signed below) — PLEASE PRINT

NAME AND ADDRESS ☐ IF ADDRESS IS INCORRECT CHECK HERE AND ENTER CORRECTION ON BACK OF FORM	ACTIVATION NUMBER
	EMAIL ADDRESS (IF AVAILABLE)
	NAME OF CREDITOR

B. DISABLED PERSON'S INFORMATION — PLEASE PRINT

NAME OF DISABLED PERSON	DISABLED PERSON IS ☐ Covered Person ☐ Other	
NAME OF EMPLOYER	TELEPHONE NUMBER (EMPLOYER) ( )	EXTENSION
DESCRIBE CURRENT ACTIVITIES OR ANY CHANGE IN CONDITION		
RETURNED TO WORK SINCE BECOMING DISABLED ☐ Yes ☐ No If, Yes ☐ Full-Time ☐ Part-Time	DATE RETURNED TO WORK / /	# OF HOURS PER WEEK
APPLIED FOR SOCIAL SECURITY DISABILITY ☐ Yes ☐ No	ARE YOU RECEIVING SOCIAL SECURITY DISABILITY? ☐ Yes ☐ No	**IF YES, ATTACH A COPY OF SOCIAL SECURITY AWARD LETTER OR VERIFICATION THAT SSDI IS BEING RECEIVED TO THIS FORM**

AUTHORIZATION: I hereby authorize that 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, 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.

COVERED PERSON'S SIGNATURE (REQUIRED) X	TELEPHONE NUMBER ( )	DATE / /

C. PHYSICIAN STATEMENT (to be furnished without expense to American Bankers Management Company) — PLEASE PRINT

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

OBJECTIVE DIAGNOSIS/FINDING	DIAGNOSIS CODE(S) FOR DISABILITY CLAIM ☐ ICD-9 _____ ☐ CPT _____ ☐ DSM III _____
DATE OF TREATMENT FOR THE LAST 6 MONTHS	FREQUENCY OF VISITS ☐ Weekly ☐ Monthly ☐ Other _____

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION ☐ Yes ☐ No	IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK / /	IF NO, DATE PATIENT WAS RELEASED TO RESUME WORK / /
LIST LIMITATIONS		

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK) FROM / / TO / /	GIVE EXACT DATES OF PARTIAL DISABILITY FROM / / TO / /
IS PATIENT PERMANENTLY DISABLED ☐ Yes ☐ No	IF PATIENT IS TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED ☐ 1-2 months ☐ 3 months ☐ 6 months ☐ Longer than 9 months ☐ Undetermined

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 SIGNATURE X	PHYSICIAN'S NAME (PRINT NAME)	MEDICAL ID#	DATE / /

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

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY PHYSICIAN'S OFFICE

A benefit verification form must be submitted with updated information every 30 days to be considered for continued benefits.

FAX COMPLETED FORM AND ANY ATTACHMENTS TO 305-259-4575 OR MAIL TO:

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

Dear Valued Customer:

Thank you for giving American Bankers Management Company the opportunity to assist you!

To be considered for continued benefit activation:

1. Complete Sections A and B.
2. Have physician complete Section C.

Please include activation number on all correspondence sent to our office. This will assure prompt and efficient handling of the information provided. Also, for faster service when calling, please have the activation number ready. After 15 business days, the activation status may be verified through the automated inquiry system by calling (800) 859-0568 Monday - Friday, 8:00 a.m. - 8:oo p.m. Eastern Time.

USAA CONSUMER LEND
11222 QUAIL ROOST DRIVE
MIAMI FL 33157-6543

NAME AND ADDRESS CORRECTION		PLEASE PRINT
NAME		
STREET ADDRESS/APT #		
CITY	STATE	ZIP CODE