INSTRUCTIONS FOR FILING A DISABILITY CLAIM

To file a disability claim, we need the completed and signed, Initial Claimant's Statement, the Authorization Concerning Medical & Financial Information and the Attending Physician's Statement.

We offer several convenient ways to return information:

Online:
1. To send documents, go to https://www.usaa.com/my/upload/
2.Enter credentials
3.Select Life & Health Insurance/Annuities

Fax: 877-435-7099
Mail:

ATTN: Life Company Claims
USAA Life Insurance Company
USAA Life Insurance Company of New York
9800 Fredericksburg Road
San Antonio, TX 78288

If you have any questions regarding your claim or these forms, please call 800-531-8455.

INSTRUCTIONS ONLY
DO NOT RETURN THIS PAGE

USAA Life Insurance Company
USAA Life Insurance Company of New York
Service Center
9800 Fredericksburg Road
San Antonio, TX 78288

ATTENDING PHYSICIAN'S STATEMENT FOR INCOME REPLACEMENT/WAIVER OF PREMIUM BENEFITS

CONFIDENTIAL

To be completed by the treating physician. Attach medical records and reports if available.

1. Patient's Name	Date of Birth	USAA Number

DIAGNOSIS AND HISTORY

2 (a.) Diagnosis (Please use ICD-ID CM codes)

2 (c.) Clinical Findings:

2 (b.) Current conditions, including symptoms

3 (a.)If Psychiatric diagnosis, complete this section. (Please use DSM-IV Codes for Axis I and II and ICD-9 CM Codes for Axis III)

Axis I.

II.

III.

3 (b.) Axis V: Global Assessment of Functioning Scale [GAF Scale]: (circle)

Initial: 90 80 70 60 50 40 30 20 10 **Current:** 90 80 70 60 50 40 30 20 10

3 (c.) If objective testing performed, please summarize or attach report(s). (Psychological, X-rays, etc.)

4. Initial onset date of symptoms:

5 (a.) Date first consulted by you:

5 (b.) Date last consulted by you:

6. Dates patient was hospitalized:

7. Specific work limitations/restrictions and date of onset.

From: Through:

Need Name and Address of Hospital.

8. Any other health care providers involved in patient's treatment. ☐ No ☐ Yes If yes, list the Name, Address and Specialty

CONSTRAINTS AND EXPECTATIONS

9. Based on documentation from your medical records, the patient was totally/partially (circle one) unable to perform job duties:
From: Through:

10. If currently disabled, when should patient be able to return to gainful employment?

11 (a.) Is this patient physically able to perform some of the duties of his/her occupation? ☐ YES ☐ NO

(b.) Can patient do any other gainful work? ☐ YES ☐ NO

12 (a.) Do you expect patient to resume some type of work? ☐ YES ☐ NO

(b.) Estimated time until recovery.

13 (a.) Provide the current plan of therapy and response

13 (b.) Has patient been compliant? ☐ Non-Compliant ☐ Excellent ☐ Fair ☐ Poor

13 (c.) Does this plan include a focus on Return to Work? ☐ YES ☐ NO

14 (a.) Other factors that may influence prognosis for recovery.

14 (b.) Additional Remarks

See page 2 - SIGNATURE REQUIRED

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 such violation.

Physician's Name (Please print)	Telephone Number ( )
Address (Street, City, State, Zip)	

Physician's Signature X	Date

ILLINOIS ISSUED CONTRACTS INFORMATION

Illinois Interest Statement - If payment is not made within 31 days after receipt of the due proof of death, interest on the claim settlement will accrue at the rate of 10% from the date of death to the date of payment for the total amount payable. The due proof of death includes but is not limited to the date the death certificate is received, documentation sufficient to determine the company's liability, and if applicable any necessary legal impediments to the payment of the death proceeds that depends on the action of parties other than the company are resolved.

Fraud Warning Disclosure
Please keep for your records

NOTICE	Under applicable state law, any person who knowingly files a claim containing false or misleading information or who conceals information with intent to defraud or mislead an insurance company or other person, may be guilty of a felony or subject to other criminal and/or civil penalties including denial of insurance benefits.
ALABAMA RESIDENTS	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
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 state law.
ARKANSAS/ DISTRICT OF COLUMBIA/ LOUISIANA/ RHODE ISLAND/ WEST VIRGINIA 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 fines and confinement in prison.
ARIZONA RESIDENTS	For your protection Arizona law requires the following statement 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.
CALIFORNIA RESIDENTS	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the 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 RESIDENTS	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
FLORIDA RESIDENTS	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
IDAHO RESIDENTS	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
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.
MAINE/ TENNESSEE/ VIRGINIA/ WASHINGTON 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.
MARYLAND RESIDENTS	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.
MINNESOTA RESIDENTS	A person who 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 RSA 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 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.
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.

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 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.

For claims assistance, please call USAA LIFE INSURANCE COMPANY/USAA LIFE INSURANCE COMPANY OF NEW YORK Toll Free at 800-531-8000.

MAIL TO: ATTN: Life Company Benefits
USAA LIFE INSURANCE COMPANY/
USAA LIFE INSURANCE COMPANY OF NEW YORK
9800 Fredericksburg Road
San Antonio, TX 78284-8499

USAA Life Insurance Company of New York
Service Center
9800 Fredericksburg Road
San Antonio, Texas 78288

HIPAA AUTHORIZATION CONCERNING MEDICAL AND FINANCIAL INFORMATIONA

PLEASE SIGN AND RETURN ONE COPY OF THIS FORM AND RETAIN A COPY FOR YOUR RECORDS

Name of Insured:
USAA Number:

I understand that the information released through this authorization will be used by USAA Life Insurance Company of New York to determine my initial and continuing eligibility for waiver of life insurance premium insurance benefits. I understand that although this authorization is voluntary, USAA Life reserves the right to decline my claim for benefits if I refuse to grant this authorization.

The information released pursuant to this authorization may no longer be protected by federal privacy regulations. USAA Life will not release identifiable health information obtained by use of this authorization outside of USAA Life, except to its reinsurers, the Medical Information Bureau (MIB), other persons or organizations performing administrative or legal services related to this claim for insurance benefits and as required by law or further authorized by the insured.

I authorize the following persons and organizations, who may have knowledge of my past or future health, activities, work, employment and financial affairs, to provide information to USAA Life Insurance Company of New York ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veterans Administration clinic, or medically-related facility; (f) MIB; (g) any psychiatrist or psychologist; (h) any health facility; (i) any prescription drug databases; (j) any consumer reporting agency; (k) any past or present employer; (l) individuals or organizations with knowledge regarding my income and earnings, tax payments or other medical or financial information relevant to my claim for benefits. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure.

For purposes of this Authorization, "information" means any printed or electronic records or unrecorded knowledge concerning the undersigned insured.

This authorization includes the release of the entire medical record of the insured including information about AIDS, HIV, drugs, alcoholism, or mental illness. This authorization allows USAA Life to obtain any medical records or information that are subject to a request for additional restriction of use and disclosure pursuant to the privacy rights granted by the Health Insurance Portability and Accountability Act.

I further authorize a consumer reporting agency to make an investigative report of me if it is requested by USAA Life and elect the opportunity to be interviewed if such report is prepared.

To facilitate rapid submission of the information requested, I authorize all sources to give such records or knowledge to any agent employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be valid as the original. I agree that this Authorization shall be valid for one (1) year from the date shown below, and that upon request, I or my authorized representative is entitled to receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request referencing my USAA number and the date of this Authorization to USAA Life. A revocation does not affect any actions taken by USAA Life in reliance on the Authorization prior to receipt of the revocation and may impair my ability to continue to receive the insurance benefits applied for.

_____ _____
Signature of Insured Date

_____ _____
Signature of Personal Representative (Indicate Relationship to Insured/Authority to Act) Date

For claims assistance, please call USAA LIFE INSURANCE COMPANY OF NEW YORK Toll Free at 800-531-8455.

Please retain a copy of this signed authorization for your records.

MAIL TO: ATTN: Life Claims
USAA LIFE INSURANCE COMPANY OF NEW YORK
Service Center
9800 Fredericksburg Road
San Antonio, Texas 78284-8499

USAA Life Insurance Company
USAA Life Insurance Company of New York
Service Center
9800 Fredericksburg Road
San Antonio, TX 78288

INITIAL CLAIMANT'S STATEMENT FOR INCOME REPLACEMENT/WAIVER OF PREMIUM BENEFITS

INSTRUCTIONS: 1. Complete page 1 and 2 of this form and sign where indicated. Please print all entries. If more space is needed, attach a separate page.

Insured's Full Name	USAA Number
Home Address (Street, City, State, Zip)	Home Telephone Number ( )
Name of Last Employer	Insured's Birth Date
Business Address (Street, City, State, Zip)	Business Telephone Number ( )

PLEASE DESCRIBE YOUR CURRENT DISABLING CONDITION AND ITS CAUSE.

Date of your accident or the date you first noticed the symptoms of your illness:	I totally stopped working due to my disability on: ☐ have not stopped	I had reduced work activity because of my disability since:	I returned to work ☐ part-time ☐ full-time ☐ have not returned
/ / Month Day Year	/ / Month Day Year	/ / Month Day Year	/ / Month Day Year

LIST ALL PHYSICIANS OR OTHER PRACTITIONERS CONSULTED.

Name	Address (Street, City, State, Zip)	Dates Consulted		

LIST ALL HOSPITAL CONFINEMENTS IN THE PAST FIVE (5) YEARS.

Name	Address (Street, City, State, Zip)	From	To	Reason Confined

OCCUPATIONAL INFORMATION

What was your occupation immediately prior to the date you became disabled? _____
Date you began this occupation _____.

DESCRIPTION OF EACH DUTY	1.	2.	3.	4.	5.
WEEKLY HOURS SPENT AT THIS ACTIVITY	hrs.	hrs.	hrs.	hrs.	hrs.

Describe which of these duties you are unable to perform as a result of your sickness or accident, and why.

Describe your prior work experience and education (include dates).

Remarks:

See page 2 - SIGNATURE REQUIRED

WHAT OTHER INCOME REPLACEMENT OR DISABILITY INSURANCE DO YOU HAVE?
(LIST GROUP AND INDIVIDUAL) ☐ NONE

Name of Company/Plan	Policy #	Policy Date	Monthly Benefit
			$
			$

Are you receiving (or have you applied for) disability benefits from:

(a) Social Security	(a) ☐ No ☐ Applied for ☐ Receive	$	Per
(b) Workers Compensation	(b) ☐ No ☐ Applied for ☐ Receive	$	Per
(c) State Disability Plan	(c) ☐ No ☐ Applied for ☐ Receive	$	Per

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SIGNATURE OF INSURED	To the best of my knowledge, the information on this form is true and complete. **X** DATE

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