



# INSTRUCTIONS FOR FILING A DISABILITY CLAIM

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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

## 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<br>( )     |
| Name of Last Employer                       | Insured's Birth Date             |
| Business Address (Street, City, State, Zip) | Business Telephone Number<br>( ) |

PLEASE DESCRIBE YOUR CURRENT DISABLING CONDITION AND ITS CAUSE.

|  |  |  |  |
|--|--|--|--|
| Date of your accident or the date you first noticed the symptoms of your illness:<br>/ /<br>Month Day Year | I totally stopped working due to my disability on:<br><input type="checkbox"/> have not stopped<br>/ /<br>Month Day Year | I had reduced work activity because of my disability since:<br>/ /<br>Month Day Year | I returned to work<br><input type="checkbox"/> part-time <input type="checkbox"/> full-time<br><input type="checkbox"/> have not returned<br>/ /<br>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

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

| Name of Company/Plan | Policy # | Policy Date | Monthly Benefit |
|----------------------|----------|-------------|-----------------|
| _____                | _____    | _____       | \$ _____        |
| _____                | _____    | _____       | \$ _____        |

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

|                           |   |          |           |
|---------------------------|---|----------|-----------|
| (a) Social Security       | (a) <input type="checkbox"/> No <input type="checkbox"/> Applied for <input type="checkbox"/> Receive | \$ _____ | Per _____ |
| (b) Workers Compensation  | (b) <input type="checkbox"/> No <input type="checkbox"/> Applied for <input type="checkbox"/> Receive | \$ _____ | Per _____ |
| (c) State Disability Plan | (c) <input type="checkbox"/> No <input type="checkbox"/> Applied for <input type="checkbox"/> Receive | \$ _____ | Per _____ |

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**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.

**SIGNATURE  
OF INSURED**

To the best of my knowledge, the information on this form is true and complete.

**X**

DATE

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**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.

|   |   |
|---|---|
| <b>ARIZONA RESIDENTS</b>  | 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.   |
| <b>CALIFORNIA RESIDENTS</b>   | 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.  |
| <b>COLORADO RESIDENTS</b>   | 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. |
| <b>DELAWARE RESIDENTS</b>   | 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.   |
| <b>FLORIDA RESIDENTS</b>  | 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.   |
| <b>IDAHO RESIDENTS</b>  | 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.  |
| <b>INDIANA RESIDENTS</b>  | 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.   |
| <b>KENTUCKY RESIDENTS</b>   | 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.   |
| <b>MAINE/<br/>TENNESSEE/<br/>VIRGINIA/<br/>WASHINGTON<br/>RESIDENTS</b> | 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.  |
| <b>MARYLAND RESIDENTS</b>   | 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.  |
| <b>MINNESOTA RESIDENTS</b>  | A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.  |
| <b>NEW HAMPSHIRE RESIDENTS</b>  | 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.  |

|                               |   |
|-------------------------------|---|
| <b>NEW JERSEY RESIDENTS</b>   | Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.  |
| <b>NEW MEXICO RESIDENTS</b>   | 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.   |
| <b>OHIO RESIDENTS</b>         | 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.   |
| <b>OKLAHOMA RESIDENTS</b>     | 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.   |
| <b>PENNSYLVANIA RESIDENTS</b> | 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. |
| <b>TEXAS RESIDENTS</b>        | 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



# HIPAA AUTHORIZATION CONCERNING MEDICAL AND FINANCIAL INFORMATION

**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 to determine my initial and continuing eligibility for income replacement or 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 ("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.

**For Oklahoma residents, the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.**

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Signature of Insured

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Date

---

Signature of Personal Representative  
(Indicate Relationship to Insured/Authority to act)

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Date

For claims assistance, please call USAA LIFE INSURANCE COMPANY 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  
                  9800 Fredericksburg Road  
                  San Antonio, Texas 78284-8499

16710-0320  
LCF707ST

LIFE BNCLSTATI



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: |
| <br><br>                                      | <br><br>                  |

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 | Current: | 90 | 80 | 70 | 60 | 50 | 40 |
|          | 30 | 20 | 10 |    |    |    |          | 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:<br>From: _____ Through: _____ | 10. If currently disabled, when should patient be able to return to gainful employment?<br>_____<br>_____ |
|---|---|

|   |   |
|---|---|
| 11 (a.) Is this patient physically able to perform some of the duties of his/her occupation? <input type="checkbox"/> YES <input type="checkbox"/> NO | (b.) Can patient do any other gainful work?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|---|

|  |  |
|--|--|
| 12 (a.) Do you expect patient to resume some type of work?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | (b.) Estimated time until recovery.<br>_____ |
|--|--|

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

|  |   |
|--|---|
| 13 (b.) Has patient been compliant?<br><input type="checkbox"/> Non-Compliant <input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Poor | 13 (c.) Does this plan include a focus on Return to Work?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|---|

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

14 (b.) Additional Remarks \_\_\_\_\_

See page 2 - SIGNATURE REQUIRED



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|                                    |                             |
|------------------------------------|-----------------------------|
| Physician's Name (Please print)    | Telephone Number<br>(     ) |
| Address (Street, City, State, Zip) |                             |
| Physician's Signature<br><b>X</b>  | Date                        |

#### ILLINOIS ISSUED CONTRACTS INFORMATION

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|   |   |
|---|---|
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| <b>ARKANSAS/<br/>DISTRICT OF<br/>COLUMBIA/<br/>LOUISIANA/<br/>RHODE ISLAND/<br/>WEST VIRGINIA<br/>RESIDENTS</b> | 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.  |
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|   |   |
|---|---|
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| <b>OHIO RESIDENTS</b>   | 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.   |
| <b>OKLAHOMA RESIDENTS</b>   | 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.   |

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|                                   |   |
|-----------------------------------|---|
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|-----------------------------------|---|

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|                            |   |
|----------------------------|---|
| <b>TEXAS<br/>RESIDENTS</b> | 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. |
|----------------------------|---|

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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