Return Completed Form To:
Plateau Group West, Attn: Claims Department
8001 Conser Street, Suite 240, Overland Park, KS 66204
1-800-752-8328 Ext. (3085) or fax 1-931-459-3107

Debt Protection
Request for Disability Benefits

Important Notes to Claimant

1. Please print throughout the form, and ensure that all fields are completed. An incomplete claim form will cause delay in assessment.
2. Mail the completed form to the address shown above.

I - Statement of Claimant

Claimant's Name: ______________________ Social Security #: ______________ Date of Birth: __________

Address: ______________________ City: ______________ State: ________ Zip Code: ________

Sex: ☐ Male ☐ Female Home Telephone #: (____) ______________ Work Telephone #: (____) ______________

Occupation and Duties: ____

Present Employer's Name: ______________________ Date Employed-from: __________ to: __________

Address: ______________________ City: ______________ State: ________ Zip Code: ________

Former Employer's Name: ______________________ Date Employed-from: __________ to: __________

Address: ______________________ City: ______________ State: ________ Zip Code: ________

Cause of Disability: ☐ Injury ☐ Sickness Describe accident or illness: ______________________

____

Date current condition first appeared: ______________________ Date of first treatment: ______________________

Have you ever had this condition before? ☐ Yes ☐ No If "Yes," date: ______________________

Information on physician who is treating you for current condition: (Include hospital where treated.)

Name	Address	City	State	Zip Code

Information on all other physicians who have treated you for this and any other condition in the past three (3) years: (Include hospitals where treated.)

Name	Address	City	State	Zip Code

First day you did not work due to current disability: __________ Date first returned, or could have returned, to any part of your work: __________
Have you applied for retirement due to this injury or sickness? ☐ Yes ☐ No Have you applied for workers compensation benefits? ☐ Yes ☐ No
Have you applied for unemployment benefits? ☐ Yes ☐No If "Yes," have benefits been approved? ☐ Yes ☐ No
Have you applied for social security disability benefits? ☐ Yes ☐ No
If "Yes," have benefits been: Approved? ☐ Yes ☐ No Declined? ☐ Yes ☐ No Pending? ☐ Yes ☐ No

By signing below, I declare that the above statements are complete and true to the best of my knowledge and belief. Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer or benefit plan administrator to provide The Plateau Group, Inc. (PGI), the program administrator, or an agent or attorney, acting on its behalf, information concerning advice, diagnosis, care or treatment provided to me, including information relating to mental illness, use of drugs, use of alcohol, acquired immunodeficiency syndrome (AIDS) or an AIDS related complex (ARC). I authorize my employer to provide PGI with employment related information. I also authorize the creditor or any transferee of the indebtedness to provide PGI with copies of my credit application and any other information regarding the credit transaction which is the basis of the protection. I understand that such information will be used by PGI for the purpose of evaluating my claim for disability benefits and that PGI may make this information available to the Lender for audit purposes. I, or any authorized representative, will receive a copy of this authorization upon request. This authorization will expire in 180 days from the date signed. I may revoke this authorization by notifying PGI. in writing of my desire to revoke it. If this authorization is revoked, PGI and/or the lender retain all of their contractual rights.

Claimant's Signature: ______________________ Date: ______________

II - Statement of Employer

Employee's Name: ______________________ Occupation and Duties: ______________________

Original Date of Employment: ______________ Date last worked due to disability: ______________

Date the employee ☐ returned or ☐ is expected to return to work: ______________

Has the employee been unable to work due to this condition before? ☐ Yes ☐ No If "Yes," please provide details, including dates on separate page.

Was this employee working at least 30 hours per week, 3 months prior to this disability? ☐ Yes ☐ No

Employer's Name: ______________________ Telephone Number: (______) ______________

Address: ______________________ City: ______________ State: ________ Zip Code: ________

Employer's Signature: ______________________ Title: ______________________ Date: ______________

III - Statement of Attending Physician

Patient's Name: ____________________ Date of Birth: ____________

	ICD-9 Diagnosis Code	Diagnosis Primary Cause(s) of Inability to Work
1.		
2.		
		Contributory Cause(s) of Inability to Work
1.		
2.		

Complications slowing recovery: ____________________

Date symptoms first appeared or accident occurred: ____________ If accident, list details of injury: ____________

____

List all dates of treatment for this condition: First treatment: ____________ All subsequent treatment dates: ____________

____

Is or was the patient unable to work because of sickness or injury? ☐ Yes ☐ No If "Yes," when: ____________

Dates patient was totally disabled: first day: ____________ last day: ____________

Has patient returned to work? ☐ Yes ☐ No Date patient was or is expected to be physically able to return to work: ____________
☐ part-time ☐ restricted duty ☐ full-time ☐ regular duty

If released to part-time or restricted duty, please list patient's specific physical restrictions: ____________

____

Is patient still under your care? ☐ Yes ☐ No If discharged, give date and reason: ____________

Has patient had the same or similar condition before? ☐ Yes ☐ No If "Yes," when: ____________

Have you treated this patient prior to this occurrence in the past three (3) years? ☐ Yes ☐ No If "Yes," please provide diagnosis and dates of treatment: ____________

Date of hospitalization, if any: from: ____________ through: ____________

Hospital Name: ____________________

Address: ____________ City: ____________ State: ______ Zip Code: ______

Nature and date of surgical procedure performed, if any: ____________

Type of treatment currently recommended for patient: ____________

Referring Physician Name: ____________

Address: ____________ City: ____________ State: ______ Zip Code: ______

Prognosis for recovery: ☐ very good ☐ good ☐ fair ☐ poor

Physician's Name: ____________ Degree: ____________

Address: ____________ City: ____________ State: ______ Zip Code: ______

Physician's Signature ____________ Date: ____________ Telephone Number: (   ) ____________

IV - Statement of Lender

Lender's Name: ____________ Reporting #: ____________ Telephone Number: (   ) ____________

Address: ____________ City: ____________ State: ______ Zip Code: ______

Protected Borrower's Name: ____________

Effective Date of Loan: ____________ Account/Loan Number: ____________ Monthly Benefit: ____________

Interest: ____________ Benefit Fee: ____________ Other: ____________

Total Benefit: ____________ Payment Due Date: ____________ Expiration Date of Loan: ____________

Authorized Representative of Lender - Name: ____________ Title: ____________

Signature: ____________ Date: ____________

Administered By
The Plateau Group, Inc.
8001 Conser Street, Suite 240, Overland Park, Kansas 66204
1-800-752-8328