Debt Protection Program
Request for Hospitalization Benefits

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Please print and complete all fields throughout the form. An incomplete claim form will cause delay in activating benefits.
2. Have your Lender/Creditor complete Section 2.
2. Have your **Physician** complete Section 3 (see page 2).
3. Mail the completed form, along with a **copy of the discharge records, bills or other documents** verifying your stay in the hospital to the address shown at the bottom of this form.

SECTION 1 – CUSTOMER INFORMATION

Customer's Name:_____ ☐ Male ☐ Female

Address: _____ City:_____ State: __ __ Zip Code: __ __ __ __ __

Social Security #: ____-___-_____ Date of Birth: ___/___/_____

Home Telephone #: (_____) _____-_____ Work Telephone #: (_____) _____-_____

What was the cause of Hospitalization: (check one) ☐ Injury ☐ Sickness

Describe accident or illness: _____

_____

Name of Hospital: _____

Address: _____ City: _____ State: __ __ Zip Code: __ __ __ __ __

Dates of Hospitalization: Admitted: __ __/__ __/__ __ __ __ Discharged: __ __/__ __/__ __ __ __

Statement of Authorization. By signing below, I declare that the statements contained herein 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 agent or attorney acting on their behalf, information concerning advice, diagnosis, care or treatment provided me including information relating to mental illness, use of drugs, use of alcohol, acquired immunodeficiency syndrome (AIDS) or an AIDS related complex (ARC). I also authorize the creditor or any transferee of the indebtedness to provide PGI with copies of my loan balance or history and any other information regarding the credit transaction that is enrolled for protection. I understand that such information will be used by PGI and the creditor for the purpose of evaluating my claim for Hospitalization benefits. This authorization will expire in 180 days from the date signed. I may revoke this authorization by notifying PGI in writing. If this authorization is revoked, PGI and/or the creditor retain all of their contractual rights.

➔ Customer's Signature: _____ Date: __ __/__ __/__ __ __ __

SECTION 2 - STATEMENT OF LENDER/CREDITOR

Lender's/ Creditor's Name: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Telephone Number: (_____) _____-_____ Reporting #: _____

Protected Borrower's Name:_____

Account/Loan Number: _____ Effective Date of Account: _____

Loan/Account Balance as of Date of Hospitalization: $_____ For credit card or line of credit account, attach a copy of the account history for the prior six months. The account history should include any/all charges, advances, the dates and the amounts.

Authorized Representative of Lender/Creditor: Name: _____ Title: _____

Signature: _____ Date: _____

Return Completed Form To:

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

SECTION 3 - STATEMENT OF ATTENDING PHYSICIAN (TO BE COMPLETED BY YOUR ATTENDING PHYSICIAN)

Patient's Name:_____ Date of Birth: __ __/__ __/__ __ __ __

	ICD-9 Diagnosis Code	Diagnosis Primary Cause(s) of Hospitalization
1.		
2.		
		Contributory Cause(s) of Hospitalization
1.		
2.		

Date of hospitalization: from: __ __/__ __/__ __ __ __ through: __ __/__ __/__ __ __ __

Hospital Name: _____

Address: _____ City: _____ State: __ __ Zip Code: __ __ __ __ __

Physician's Name: _____ Degree:_____

Address: _____ City: _____ State: __ __ Zip Code: __ __ __ __ __

Physician's Signature _____ Date: __ __/__ __/__ __ __ __

Telephone Number: (__ __ __) __ __ __ - __ __ __ __

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