Bank of America

PROTECTION PLAN SERVICES
PO Box 25146
Santa Ana, CA
92799-5146

TO EXPEDITE YOUR BENEFIT REQUEST, FAX TO 866.380.6718

FOR QUESTIONS, CALL TOLL FREE 866-317-5116

**Borrowers/Line Protection Plan®**

# DISABILITY INITIAL BENEFIT ACTIVATION FORM

**Protected Borrower's Report – Borrower must complete all information in this section.**

1. Loan Account Number(s) _____ _____
2. Borrower's Full Name _____ Date of Birth _____
   Address _____
   _____ Telephone (____) _____
   City _____ State _____ Zip Code _____
3. Occupation _____
4. Employer's Name _____
   Address _____
   _____ Telephone (____) _____
   City _____ State _____ Zip Code _____
5. If reimbursement is needed for payments that you have made during an approved benefit period, may we place the funds in your Bank of America checking account? ☐ Yes ☐ No
6. If yes, please sign your name and list your Bank of America checking account number below.

_____ _____
(Your Signature) (Your Checking Account Number)

**INSTRUCTIONS – Please read before filling out this benefit activation form.**

1. **There is a waiting period.** You must be disabled and under the care of a licensed physician (other than yourself) that is certified to practice medicine in the United States or its territories for at least the waiting period before your benefit request is eligible for consideration. SECTION 1 and SECTION 2 below must not be completed until after the waiting period has been satisfied. **Completion prior to the end of the waiting period will require a new form be completed.**
   **Note: If you return to work you may not be eligible for future benefits. Work includes any job or business for which you receive wages or profits.**
2. Please sign and date the enclosed **HIPAA COMPLIANT CONDITIONAL AUTHORIZATION** and return it with the completed benefit activation form.
3. Please review your **Borrowers/Line Protection Plan Addendum** under the **Disability** section for the full details on eligibility for Disability benefits.

## DISABILITY BENEFIT INFORMATION

**SECTION 1 Borrower must complete, date and sign this section.**

1. Date you were first unable to work entirely because of present disability ____/____/____ (mm/dd/yyyy)
2. Date symptoms of this sickness first appeared ____/____/____ (mm/dd/yyyy)
3. Is this disability the result of an accident YES _____ Date of accident ___/____/___ NO _____
4.. Have you returned to regular or light duty work? ☐ Yes ☐ No
   If yes, date returned to work ____/____/____ (mm/dd/yyyy)
   If no, date you expect to return to work ____/____/____ (mm/dd/yyyy)
5. Are you under the continuous care of a licensed physician that is certified to practice medicine in the United States or its territories (other than yourself) as a result of your disability?
   ☐ Yes ☐ No

**PLEASE CONTINUE ON REVERSE SIDE**

**SECTION 1 (Continued) Borrower must complete, date and sign this section.**

6. List all licensed physicians who treated you for this disability, as we may need to contact them.

| PHYSICIAN'S NAME(S) | TELEPHONE NUMBER(S) | DATE(S) OF TREATMENT |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**BORROWER'S AUTHORIZATION:** I _____ (print name) CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE ANY EMPLOYER OR OTHER ORGANIZATION, OR PERSON HAVING ANY RECORDS, DATA OR INFORMATION CONCERNING THIS BENEFIT REQUEST TO FURNISH SUCH RECORDS, DATA, OR INFORMATION TO BANK OF AMERICA CORPORATION OR ITS AUTHORIZED REPRESENTATIVE AS REQUESTED. I UNDERSTAND IN EXECUTING THIS AUTHORIZATION, I WAIVE THE RIGHT FOR SUCH INFORMATION TO BE PRIVILEGED. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Borrower's Signature **X** _____ Date ____/____/____ (mm/dd/yyyy)

**SECTION 2 Physician's Statement – The physician that <u>first</u> considered you unable to work must complete, date and sign this section.**

1. Patient's name _____
2. Diagnosis _____
3. Date of onset ____/____/____ (mm/dd/yyyy)
4. When did patient first consult you for this condition? ____/____/____ (mm/dd/yyyy)
5. Date(s) of treatment for this condition ____/____/____ ____/____/____ ____/____/____ (mm/dd/yyyy)
6. Is disability due to a pregnancy complication Yes _____ No _____
   C-section? Yes _____ No _____, Delivery date _____/____/____
7. Dates of total continuous disability From ____/____/____ Through ____/____/____ (mm/dd/yyyy)
8. Probable further total disability should not exceed 1 2 3 4 5 6 7 8 9 ☐ Weeks ☐ Months ☐ Permanent
9. Physician's name _____
   Signature **X** _____ Date ____/____/____ (mm/dd/yyyy)
   Street _____ Telephone (_____) _____
   City _____ State _____ Zip Code _____

**SECTION 3 Employer's Statement – Employer must complete, date and sign this section. (If you are self-employed, you must complete, date and sign this section)**

1. Employee's Starting date ____/____/____ (mm/dd/yyyy)
2. Date employee last worked due to disability ____/____/____ (mm/dd/yyyy)
3. Date employee resumed any work ____/____/____ (mm/dd/yyyy)
4. Was the employee absent without pay in the 90 days before ceasing work due to the disability? ☐ Yes ☐ No
   If yes, did you still consider them a full-time employee? ☐ Yes ☐ No
5. How many hours per week did the employee work? _____
   Name of Employer _____ Phone Number _____
6. Name of Employee completing this section _____ Title _____
   Signature **X** _____ Date ____/____/____ (mm/dd/yyyy)

**PLEASE SIGN AND DATE THE ENCLOSED HIPAA COMPLIANT CONDITIONAL AUTHORIZATION**

## HIPAA COMPLIANT CONDITIONAL AUTHORIZATION TO USE FOR PERSONAL HEALTH INFORMATION

1. **Purpose**.
This document is executed to ensure that your **Borrowers/Line Protection Plan®** program issued through **Bank of America** does not obtain, use or disclose legally protected health and medical information about you without obtaining your permission or for purposes other than those that are permitted by law.

2. **Type of Information Requested**.
We request your permission to obtain, use and disclose the following type of information about you for the limited purposes identified herein:

* Individual benefit activation information, including historical data.

*Information necessary for determining your eligibility for benefit activation under your **Borrowers/Line Protection Plan** program. We may request the following information from your physician or employer or other health care provider.

Your full name, date of birth, diagnosis codes, description of illness, date symptoms first appeared or accident happened, your ability to perform work for wages or profit, your last day worked, date you were permitted to return to work, estimation as to when you may be able to return to work, employment status, your prognosis for recovery, whether or not you will ever return to your occupation, whether or not you will be able to return to any occupation for wages or profit, are you permanently and totally disabled, date of your permanent and total disability.

3. **Purpose For Which Information Will Be Shared**.
The information identified above will be shared only for purposes of determining eligibility for or activating of benefits under the **Borrowers/Line Protection Plan.**

4. **Persons Authorized To Make Disclosures**.
The following persons are authorized to make the requested uses and disclosures of the information identified herein: **Bank of America**, it's administrator, agents or representatives or any other person or entity performing services or functions on behalf of **Bank of America** in connection with the **Borrowers/Line Protection Plan**.

5. **Persons to Whom Disclosures May Be Made**.
The information identified herein will be disclosed by **Bank of America** only to its administrator, agents or representatives or any other person or entity performing functions on behalf of Bank of America in connection with the **Borrowers/Line Protection Plan**.

6. **Expiration Date / Revocation**.
This authorization shall remain in effect for as long as **Bank of America** retains the information. However, you retain the right to revoke this authorization before that date by sending a signed written request to the following address: **Borrowers/Line Protection Plan**, P.O. Box 25146 Santa Ana, CA 92799-5146.

7. **Effect of Refusal to Sign Authorization or Revocation of Authorization**
Your refusal to sign this document or subsequent revocation of this signed authorization may be used as the basis for denying you benefit activation.

8. **Reuse/Redisclosure of Information**.
Information disclosed under this authorization is subject to redisclosure by the recipient; however, any information disclosed to health care providers, agents or representatives, health plans and health plan administrators, will continue to be protected and not be reused or redisclosed other than as authorized by you or permitted by law.

9. **Certification and Authorization.**
I have read and understand the information above and hereby with my signature below authorize the receipt, use and disclose of the information described in this document for the limited purposes identified herein. I acknowledge that no promises or representations have been made to me as an inducement to sign this form. I hereby certify that the information given here is true and correct. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

IMPORTANT TAX INFORMATION: Benefits provided by the Borrowers Protection Plan and Line Protection Plan may be taxable income and may also reduce the amount of interest reported to the IRS on form 1098. Consult a tax advisor regarding the tax impact of benefits.

Borrower's Name (Printed) _____

Borrower's Signature **X**_____ Date ____/____/____ (mm/dd/yyyy)