



c/o Benefit Activation Department, PO Box 977122, Miami, FL 33197-7122

CONTINUING
DISABILITY/HOSPITALIZATION
BENEFIT VERIFICATION FORM

Please see instructions on the reverse side of this benefit verification form.

A. CARDMEMBER INFORMATION (must be completed and signed below) PLEASE PRINT
NAME AND ADDRESS IF ADDRESS IS INCORRECT CHECK HERE AND ENTER CORRECTION ON BACK OF FORM
ACTIVATION NUMBER
E-MAIL ADDRESS (IF AVAILABLE)
NAME OF CREDITOR

B. DISABLED/HOSPITALIZED PERSON'S INFORMATION PLEASE PRINT
NAME OF DISABLED/HOSPITALIZED PERSON
DISABLED/HOSPITALIZED PERSON IS
NAME OF EMPLOYER
TELEPHONE NUMBER (EMPLOYER) EXTENSION
DESCRIBE CURRENT ACTIVITIES OR ANY CHANGE IN CONDITION
RETURNED TO WORK SINCE BECOMING DISABLED
DATE RETURNED TO WORK # OF HOURS PER WEEK
APPLIED FOR SOCIAL SECURITY DISABILITY
ARE YOU RECEIVING SOCIAL SECURITY DISABILITY
IF YES, ATTACH A COPY OF SOCIAL SECURITY AWARD LETTER OR VERIFICATION THAT SSDI IS BEING RECEIVED TO THIS FORM

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, government authority, or any past or present employer to furnish USAA Debt Protection Plan Administrator or its representatives, any information related to my health, medical history diagnosis, treatment or employment. I understand that I have the right to receive a copy of this authorization. A photocopy of this authorization shall be considered as effective and valid as the original.

This authorization shall remain valid for the remaining term of activation.

Any person who knowingly and with intent to defraud any corporation or person, files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent act, which is a crime, and is subject to criminal prosecution and civil penalties.

CARDMEMBER OR JOINT CARDHOLDER SIGNATURE (REQUIRED)
TELEPHONE NUMBER
DATE

C. PHYSICIAN STATEMENT (to be furnished without expense to American Bankers Management Company) PLEASE PRINT
PATIENT'S FULL NAME
PATIENT'S STREET ADDRESS/APT. #
CITY
STATE
ZIP CODE
AGE
OBJECTIVE DIAGNOSIS/FINDING
DIAGNOSIS CODE[S] FOR DISABILITY CLAIM
DATES OF TREATMENT FOR THE LAST 6 MONTHS
FREQUENCY OF VISITS
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION
IF YES, ESTIMATE THE DATE THE PATIENT CAN RETURN TO WORK
IF NO, DATE PATIENT WAS RELEASED TO RESUME WORK
LIST LIMITATIONS
GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)
GIVE EXACT DATES OF PARTIAL DISABILITY
IS PATIENT PERMANENTLY DISABLED
IF PATIENT IS TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED
I hereby certify that the above-described information is based upon reasonable medical probability and is true and correct to the best of my knowledge and belief.
PHYSICIAN SIGNATURE
PHYSICIAN'S NAME (PRINT NAME)
MEDICAL ID #
DATE
STREET ADDRESS
CITY
STATE
ZIP CODE
TELEPHONE NUMBER
FAX NUMBER

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY PHYSICIAN'S OFFICE

A benefit verification form must be submitted with updated information every 30 days to be considered for continued benefits.

**FAX COMPLETED FORM AND ANY ATTACHMENTS TO 305-259-4575 OR MAIL TO:**

**USAA Debt Protection  
c/o Benefit Activation Department  
PO Box 977122  
Miami, FL 33197-7122**

Dear Valued Cardmember:

Thank you for giving American Bankers Management Company the opportunity to assist you!

To be considered for continued benefit activation:

1. Complete Sections A and B.
2. Have physician complete Section C.

Please include activation number on all correspondence sent to our office. This will assure prompt and efficient handling of the information provided. Also, for faster service when calling, please have activation number ready. After 15 business days, the activation status may be verified through the automated inquiry system, Monday - Friday, 8:00 a.m. - 8:00 p.m., Eastern time by calling (800) 859-0568 .

NAME AND ADDRESS CORRECTION		PLEASE PRINT
NAME		
STREET ADDRESS/APT. #		
CITY	STATE	ZIP CODE

USAA  
11222 QUAIL ROOST DRIVE  
MIAMI FL 33157-6543