Disability Income Plan
PO Box 2465
Birmingham AL 35201-2465
Website: ada.protective.com
Phone: 866-257-0707 | Fax: 303-262-5462
Email: adaclaims@protective.com

SUPPLEMENTAL MEMBER STATEMENT PLAN 1105

Name: _____ Date of Birth: _____ ADA# _____ Claim# _____

Present Address: _____

City: _____ State: _____ Zip Code: _____ Telephone No. : _____

☐ Check here if Change of Address

Progress

1. Has there been any change in your condition since your last report? ☐ Yes ☐ No
2. If yes, please explain the nature and extent of the change in condition:

_____
_____
_____

3. Briefly describe how your disabling condition impacts your daily activities:

_____
_____

Treatment

1. Please provide complete information about the physicians you have seen during the past 12 months.

Doctor's full name, address and telephone number:
_____
_____
_____

Date of your last visit: _____
Date of you next visit: _____
Condition being treated: _____
_____

Doctor's full name, address and telephone number:
_____
_____
_____

Date of your last visit: _____
Date of you next visit: _____
Condition being treated: _____
_____

2. Have you been hospital confined since your last report? ☐ Yes ☐ No
   If yes, please list name and address of hospital:

_____
_____

3. Condition being treated: _____
   Date of Admission: _____ Date of Discharge: _____

Work Activities

1. Have you returned to work in any capacity since your last report? ☐ Yes ☐ No Date returned: _____
2. If yes, is this a new occupation? ☐ Yes ☐ No Job Title: _____
3. Describe your current work activities and schedule:

_____
_____
_____

4. Do you participate in any volunteer activities? Please describe:

_____
_____

Residual Disability

If you have returned to work in your pre-disability occupation, you will need to provide documentation of your prior and current Individual Monthly Production in order to determine your eligibility for a Residual Disability Monthly Income Benefit.

Required documentation:

1. Copies of your *individual monthly* production reports for the 24 month period just prior to the date you became disabled.
2. Copies of your *individual monthly* production reports beginning with the month in which you returned to work on a part-time basis.

Please ensure these reports include description of service with applicable Current Dental Terminology (CDT) Codes and charges for the services provided.

Are you handling your own business affairs? ☐ Yes ☐ No
If no, please provide documentation showing who has legal Power of Attorney, unless previously provided.

If you are receiving other disability benefits, has there been a change in status since your last report? Yes __ No___
If Yes, please explain:

I hereby certify that I have carefully read the foregoing questions and fully understand them, and that each answer is true and complete to the best of my knowledge and belief. I further understand Protective Life & Annuity Insurance Company (PLAIC) and Protective Life Insurance Company (PLICO) (the Company) or its representative may request from time to time any documents which I have in my possession, supporting this statement, and I hereby agree to furnish them upon request. It is understood that the Company will make an independent investigation of this claim.

Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, having any records or knowledge of any illness, injury, medical history or treatment I have had, to furnish Protective Life & Annuity Insurance Company (PLAIC) and Protective Life Insurance Company (PLICO) (the Company) all such information.

The information requested by the Company may include information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including consultations after the date this authorization is signed. Any other information the Company believes to be necessary to determine eligibility for insurance benefits may also be requested.

The information collected will be used for determining eligibility for benefits under any policies issued by the Company and for other business purposes in connection with the insurance relationship. All or part of the information collected may be sent to the Company's reinsurers, and to other insurance companies with whom I have insurance or to whom I apply for insurance. Information may be sent to persons performing business or legal functions of the Company or to persons conducting research studies or audits.

The authorization shall continue to be valid for twelve months from the date it is signed. A photocopy of this signed authorization shall be as valid as the original. I may request a copy of this authorization.

State statutes in Idaho, New York, and Florida require the following language: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false or misleading information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in Florida, a felony of the third degree.)

Printed Name Signature* Date

If this form is signed by someone other than the Member, please provide name and relationship.