



PROTECTION PLAN SERVICES

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https://www.bankofamerica.com/insurance/borrowers-protection-plan-benefits.go

Borrowers/Line Protection Plan

Benefit Number: _____

Disability Continuing Benefit Activation Form

Instructions for Completing the Benefit Activation Form

- Complete all sections by hand. We will return typed forms.
Print your name and address at the top of pages 2 and 3.
Please review your Borrowers/Line Protection Plan Addendum under the Disability section for full details on protected events.
Incomplete sections or missing signatures will cause delays in processing your benefit.

1 Protected Borrower's Information - You must complete all information in this section.

List all loan account numbers protected by Borrowers/Line Protection Plan: _____

Your Full Name _____ Date of Birth ____/____/____

Billing Address _____ Home phone (____) _____
This is the address where you receive your loan correspondence

City _____ State _____ Zip _____ Cell phone (____) _____

2 Protected Borrower's Disability Information - You must complete all information in this section.

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.

1. Has your condition changed since your last report? [] Yes [] No
If yes, please explain _____

2. Have you returned to regular or light duty work? [] Yes [] No
If yes, date returned to work ____/____/____

If no, date you expect to return to work ____/____/____

Benefit Number _____ Protected Borrower's Full Name _____
 Address _____
 City _____ State _____ Zip Code _____

3 Physician's Statement – Your attending physician must complete, date and sign this section.

I hereby certify that
 (Patient's name) _____

1. Was RELEASED to return to work on _____ / _____ / _____ with restrictions without restrictions
 Continues to be DISABLED from (diagnosis) _____

and is still being regularly treated by me.

2. When do you expect the patient will be able to return to work? _____ / _____ / _____
 3. Most current date of treatment _____ / _____ / _____
 4. Probable further disability should not exceed 1 2 3 4 5 6 7 8 9 _____ Weeks _____ Months from the date you
 are completing this form or Permanently

Attending physician's name _____
 (please print)

Signature X _____ Date _____ / _____ / _____
 Street _____ Telephone (_____) _____
 City _____ State _____ Zip Code _____

4 Disclosures & Authorizations – Make sure you read and sign the disclosure statement. Failure to sign below may delay processing of your benefit.

4A Important Tax Information

Benefits provided by Borrowers/Line Protection Plan may be taxable income to you, your estate or survivors, and may reduce the amount of interest reported to the IRS on Form 1098. Consult a tax advisor regarding the tax impact of benefits.

4B Advance Reimbursement Information – Borrowers Protection Plan® only (for customers with Bank of America checking or savings accounts)

If your monthly payment is automatically debited from your checking or savings account each month under a Payplan, you may be reimbursed in advance for monthly payment amounts entitled to cancellation under Borrowers Protection Plan. These amounts will be automatically debited from your account as regularly scheduled. The advance reimbursements may be issued by check or by electronic deposit to your Bank of America checking account. The advance reimbursement amounts are solely intended to cancel the applicable monthly payment and must remain in your account so they can be automatically debited as regularly scheduled.

Please see the next page for the required Signature and Authorization to Obtain Information.

Benefit Number _____ Protected Borrower's Full Name _____
Address _____
City _____ State _____ Zip Code _____

4C **Protected Borrower's Signature and Authorization to Obtain Information – Protected Borrower must complete and sign this section. Unsigned forms will not be processed.**

By signing below, I _____ (print full name) certify that the above information is true and correct. If any of my answers to the questions on this form are not true, I understand my benefit request may be denied and, if the benefit has already been processed, I understand I will be required to pay any amounts cancelled by the plan.

By signing below:

- I authorize any employer, insurance company, governmental entity (federal, state or local) or other organization, institution or person having any records, data, information or knowledge of me, past or present, to furnish same to Bank of America, N.A., its affiliates or their authorized representative as requested and permit Bank of America, its affiliates or their authorized representative to examine and copy any such information, for the purpose of reviewing my request for benefits. I understand in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization, or the original, shall be valid from the date signed below until the conclusion of the benefit or, if later, until it is revoked by me in writing. I acknowledge that I have a right to a copy of this authorization upon request;
- I acknowledge that I have read the "Important Tax Information" and "Advance Reimbursement Information" disclosures above; and
- I acknowledge and agree that I have received a copy of, have read, and am familiar with the Borrowers/ Line Protection Plan addendum containing the terms and conditions of the plan.

Signature X _____ Date _____

REMINDER: Form must be signed. Unsigned forms will not be processed.