PROTECTION PLAN SERVICES
PO Box 961290
TX2-977-01-39
Fort Worth, TX 76161-9873
FAX: 1.866.380.6718
PHONE: 1.866.317.5116
https://www.bankofamerica.com/insurance/borrowers-protection-plan-benefits.go

Borrowers/Line Protection Plan

Benefit Number: _____

Disability Initial 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 through 4.
- Review the "How to Complete Your Disability Benefit Activation Form" to help you fill out this form. You can also call 1.866.317.5116 for help from a customer care representative.
- 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.

1. Date you were first unable to work entirely because of present disability ____/____/____
2. Date of injury or date symptoms of this sickness first appeared ____/____/____
3. Is this disability the result of an accident? ☐ Yes ☐ No

   If **yes**, what was the date? ____/____/____
3. Have you returned to regular or light duty work? ☐ Yes ☐ No

   If **yes**, what was the date? ____/____/____ If **no**, date you expect to return to work ____/____/____
4. Are you under the continuous care of a licensed physician (other than yourself) because of your disability? ☐ Yes ☐ No
5. 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

Benefit Number _____ Protected Borrower's Full Name _____

Address _____

City _____ State _____ Zip Code _____

Have you been hospitalized as a result of your disability for two nights or more in a row?

✔ If **yes**, you may also be eligible for a Hospitalization benefit. Please include a copy of your hospital bill that shows your name as the patient, the admit and discharge dates, the diagnosis, and the hospital name.

3 Physician's Statement – complete, date and sign this section.

Note to Physician: This information will be used to determine if Borrowers/Line Protection Plan Disability benefits will be granted.

1. Patient's name _____
2. Diagnosis _____
3. Date of onset ___/___/___
4. When did patient first consult you for this condition? ___/___/___
5. Date(s) of treatment for this condition ___/___/___ ___/___/___ ___/___/___
6. Is disability due to a pregnancy complication? ☐ Yes ☐ No
   C-section? ☐ Yes ☐ No Delivery date ___/___/___
7. Dates of continuous disability ___/___/___ Through ___/___/___
8. 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

Physician's name (please print) _____

Signature X _____ Date ___/___/___

Street _____ Telephone (___) _____

City _____ State _____ Zip Code _____

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

Note to Employer: This information will be used to determine if Borrowers/Line Protection Plan Disability benefits will be granted.

1. Employee's starting date ___/___/___
2. Date employee last worked due to disability ___/___/___
3. Date employee resumed any work ___/___/___
4. Was the employee absent without pay in the 90 days before ceasing work due to your 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 _____ Telephone (___) _____

Name of Employee completing this section _____ Title _____

Signature _____ Date ___/___/___

Benefit Number _____ Protected Borrower's Full Name _____

Address _____

City _____ State _____ Zip Code _____

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

5A 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.

5B 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.

5C 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. I further understand that the information may be shared with third parties as permitted or required by law. 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.

5D Authorization to Refund Your Bank of America Checking Account— If you do not own a Bank of America checking account, this section does not apply.

If we need to refund payments you made during your benefit period, or otherwise issue reimbursements, the fastest way to receive the refund is to deposit the money into your Bank of America checking account. Please provide your Bank of America checking account number below, if applicable.

Your signature authorizes us to deposit the refund into your Bank of America checking account.

_____ _____

(Your Signature) **(Your Checking Account Number)**

Benefit Number _____ Protected Borrower's Full Name _____

Address _____

City _____ State _____ Zip Code _____

5E AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION — PLEASE SIGN AND DATE THE ENCLOSED AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

1. Purpose.
Once executed, this document ensures that your **Borrowers/Line Protection Plan** program issued through **Bank of America** does not obtain, use or disclose medical information about you without obtaining your permission or for purposes other than those that are permitted or required by law.

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

The term "medical information" –
(1) means information or data, whether oral or recorded, in any form or medium, created by or derived from a health care provider or the consumer, that relates to –
(A) the past, present, or future physical, mental, or behavioral health or condition of an individual;
(B) the provision of health care to an individual; or
(C) the payment for the provision of health care to an individual.

As an example, we may request and obtain the following information from your physician or your 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 for purposes of determining eligibility for or activating of benefits or continuing benefits under the **Borrowers/Line Protection Plan**. The information may also be shared as permitted or required by law.

4. Persons Authorized To Make Disclosures.
The following persons are authorized to collect, use and disclose the medical information identified herein: **Bank of America**, its 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** 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**. The information may also be shared with third parties as permitted or required by law.

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**, Mail Stop: NC4-105-02-09, PO BOX 21848, Greensboro, NC 27420.

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 delaying and/or denying your 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 collection, use and disclosure of the medical information described in this document for the 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.

Protected Borrower's Name (Printed) _____

Protected Borrower's Signature X _____ **Date** ____/____/____