



Community of Healthcare
EMPLOYEES CREDIT UNION

MEMBER CREDIT DISABILITY AUTHORIZATION FORM

Member Name: _____ Member Account # _____

Address: _____ Loan # _____

Last Day of Work: _____

- In order for my claim to be processed accurately, I understand I must forward all disability forms and documents to the perspective persons (ex. employer, physician and CUNA Mutual) in a timely matter.
- I understand ALL disability claims received by the credit union will be applied directly to my loan, regardless if the loan is past due or paid to date. The only exception to this policy will be if the due date on the loan is after the benefit period paid by the disability check.
- In the event that the loan has overpayments due to any reason, including the reporting of my disability status, I will be responsible for the reimbursement to CUNA Mutual.
- I also understand that while receiving disability claims on the loan, any double posting of payments either by payroll deduction or cash payments will be adjusted **after** CUNA Mutual closes the claim.

Signature: _____ Date: _____

CREDIT UNION USE:

Date Claim sent to CUNA Mutual: _____

Loan due date as of Claim date: _____

Date Claim closed by CUNA Mutual: _____

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