

- Continental Assurance Company
- Valley Forge Life Insurance Company
- Continental Casualty Company
- American Casualty Company
- CNA Casualty of California
- Columbia Casualty Company
- Valley Forge Insurance Company
- National Fire Insurance Company
- CNA Life and Annuity Company
- Transcontinental Insurance Company
- Transportation Insurance Company



For All the Commitments You Make<sup>®</sup>

CNA Plaza  
Chicago, Illinois 60685

A Stock Company  
Herein called the Company

### AUTHORIZATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide the Company designated above or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide the Company designated above with financial or employment-related information.

I understand that such information will be used by the Company designated above for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request.

I also authorize the Company designated above or its reinsurers to request a report from the Medical Information Bureau (MIB) which is an association of life insurance companies that operates the Health Claims Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the name(s) of the companies but does not contain medical or other personal information. I understand that the Company designated above may also report to MIB the date(s) of any past or present claims filed by me.

This authorization is valid from the date signed for the duration of the claim.

I agree that a photographic copy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Name of Patient/Employee (or Deceased)

\_\_\_\_\_  
Date Signed (Mo./Day/Year)

\_\_\_\_\_  
Authorized Representative, or Next of Kin  
Signature of Patient/Employee

(If Patient/Employee is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. If Patient/Employee is deceased, Personal Representative or next of kin must sign).

# SUBMIT THIS FORM ONLY WHEN YOU HAVE A CLAIM



**STATEMENT OF CLAIMANT**

**APPLICATION FOR ACCIDENTAL PERMANENT TOTAL DISABILITY**

CLAIM NO: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

GROUP POLICYHOLDER: \_\_\_\_\_

INSURED PERSON: \_\_\_\_\_

EMPLOYER'S NAME AND FULL ADDRESS: \_\_\_\_\_

YOUR OCCUPATION: (DESCRIBE FULLY VARIOUS DUTIES): \_\_\_\_\_

DATE OF EMPLOYMENT: \_\_\_\_\_

AVERAGE MONTHLY EARNINGS: \_\_\_\_\_

1. DATE ACCIDENT OCCURRED: \_\_\_\_\_

2. TIME: \_\_\_\_\_ A.M. ( ) P.M. ( )

3. EXACT LOCATION: \_\_\_\_\_

4. DID INJURY OCCUR IN COURSE OF ANY EMPLOYMENT? \_\_\_\_\_

5. HAVE YOU, OR DO YOU INTEND TO FILE THIS CLAIM UNDER WORKER'S  
COMPENSATION? \_\_\_\_\_

6. NAME AND ADDRESS OF THE WORKER'S COMPENSATION CARRIER CLAIM OFFICE  
HANDLING YOUR CLAIM? PLEASE INDICATE THE CLAIM NUMBER APPLIED. \_\_\_\_\_

7. STATE IN DETAIL THE NATURE OF INJURY (Submit a copy of any available  
accident record.): \_\_\_\_\_

8. DESCRIBE HOW THE ACCIDENT OCCURRED: \_\_\_\_\_

9. NAMES AND ADDRESSES OF WITNESSES: \_\_\_\_\_

10. HAVE YOU ENGAGED IN ANY GAINFUL OCCUPATION SINCE THE DATE OF THE  
INJURY, FULL OR PART-TIME? SHOW DATES OF ANY PERIOD OF EMPLOYMENT.  
DESCRIBE THE DUTIES PERFORMED. \_\_\_\_\_

11. DATE LAST WORKED? \_\_\_\_\_

12. DATE OF FIRST MEDICAL TREATMENT? \_\_\_\_\_

13. NAME AND ADDRESS OF THE FIRST PHYSICIAN CONSULTED? \_\_\_\_\_

# **CNA GROUP BENEFITS**

P O BOX 946790  
Maitland, FL 32794-6790

- 
14. NAMES AND ADDRESSES OF ALL OTHER PHYSICIANS CONSULTED? \_\_\_\_\_
- 
15. NAMES AND ADDRESSES OF HOSPITALS AND DATES OF ADMISSION TO EACH:  
\_\_\_\_\_  
\_\_\_\_\_
- 
16. HAVE YOU BEEN CONFINED TO THE HOUSE? YES ( ) NO ( )  
IF YES, GIVE DATES. \_\_\_\_\_
- 
17. WHAT IS THE EXTENT OF YOUR PRESENT ROUTINE? \_\_\_\_\_
- 
18. WHAT IS/ARE THE CONDITION(S) WHICH PRESENTLY DISABLE(S) YOU?  
\_\_\_\_\_
- 
19. WHAT ARE THE PHYSICAL LIMITATIONS IMPOSED UPON YOU BY (EACH OF) THE ABOVE CONDITION(S)? \_\_\_\_\_
- 
20. IN WHAT WAY ARE YOU PREVENTED FROM ENGAGING IN A SUITABLE, GAINFUL OCCUPATION FOR WAGE OR PROFIT? \_\_\_\_\_
- 
21. NAMES OF OTHER INSURANCE COMPANIES AND AMOUNT IN EACH. (ACCIDENT, DISABILITY, HOSPITAL OR MEDICAL EXPENSE)  
\_\_\_\_\_  
\_\_\_\_\_
- 
22. HAVE THE CONDITIONS WHICH CURRENTLY DISABLED YOU EVER CAUSED YOU PREVIOUS TROUBLE? Yes ( ) No ( )  
IF SO, WHEN? \_\_\_\_\_
- 
23. NAME OF TREATING DOCTORS AND HOSPITALS AT THAT TIME? \_\_\_\_\_
- 
24. WHAT PLANS HAVE YOU AT PRESENT AS TO YOUR FUTURE MEDICAL TREATMENT? AS TO FUTURE EMPLOYMENT ? \_\_\_\_\_
- 
25. HAVE YOU EVER BEEN UNDER THE CARE OF A DOCTOR FOR ANY OTHER CONDITION? IF SO, PLEASE INDICATE THE NATURE OF THE CONDITION, THE NAME AND ADDRESS OF THE DOCTOR AND HOSPITAL TREATING YOU, AS WELL AS THE DATES OF ADMISSION. \_\_\_\_\_
- 
26. PLEASE GIVE A BRIEF RESUME' OF YOUR EDUCATION, TRAINING AND EXPERIENCE: \_\_\_\_\_

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27. PREVIOUS EMPLOYERS - LAST TEN YEARS - DATES OF EMPLOYMENT AND DUTIES PERFORMED? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

28. HAVE YOU PRESENTED CLAIM FOR SOCIAL SECURITY DISABILITY?  
YES ( ) NO ( ) IF YES, PLEASE INDICATE THE DISPOSITION OF THAT CLAIM BY SUBMITTING A COPY OF THEIR AWARD OR DENIAL LETTER.

29. ARE YOU, AT THE PRESENT TIME, MAKING A CLAIM UNDER THE ABOVE CITED POLICY FOR AN ACCIDENTAL PERMANENT TOTAL DISABILITY INDEMNITY, ON THE BASIS THAT YOUR DISABILITY IS CAUSED BY BODILY INJURY DUE TO AN ACCIDENT OCCURRING DIRECTLY AND INDEPENDENTLY OF ALL OTHER CAUSES, TO THE EXTENT THAT AS A RESULT OF THIS INJURY YOU ARE TOTALLY AND PERMANENTLY DISABLED FROM ENGAGING IN EACH AND EVERY OCCUPATION OR GAINFUL EMPLOYMENT FOR WAGE OR PROFIT FOR WHICH YOU MIGHT BE SUITED BY REASON OF YOUR EDUCATION, TRAINING OR EXPERIENCE?

YES ( ) NO ( ) IF SO, AT WHAT TIME DID YOU FIRST BECOME PERMANENTLY, TOTALLY DISABLED? \_\_\_\_\_

WHAT IS THE AMOUNT OF INDEMNITY YOU ARE CLAIMING? \_\_\_\_\_

YOUR SIGNATURE: \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_

CITY AND STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TELEPHONE: ( ) \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

YOUR SOCIAL SECURITY #: \_\_\_\_\_

RETURN TO: GARDNER & WHITE  
INSURED CLAIMS DEPT.  
P.O. BOX 40948  
INDPLS, IN 46240-0948