1905 Teal Road
P O Box 7007
Lafayette, Indiana 47903
800-243-6631
FAX 765-477-3236

STATEMENT OF CLAIM FOR WAIVER OF PREMIUM - GROUP LIFE INSURANCE

TO BE COMPLETED BY PATIENT (INSURED)?

Name of Claimant (Print)					Date of Birth		Social Security No.
Present Address	No.	Street	City	State		Zip	Phone No.
Policyholder (i.e., Employer, Union or Association through whom insured)					Policy No.		Amount of Insurance

ATTENDING PHYSICIAN'S STATEMENT

1. HISTORY

(a) When did symptoms first appear or accident happen? Mo. ________ Day ________ 19 ____

(b) Date patient ceased work because of disability. Mo. ________ Day ________ 19 ____

(c) Has patient ever had same or similar condition?
If "Yes" state when and describe — Yes ☐ No ☐

2. PRESENT CONDITION

(a) Subjective symptoms — (a) ____________________

(b) Objective findings — (b) ____________________

Include results of current x-rays, E.K.G.'s or any other special tests

(c) Is patient .... Ambulatory? ☐ Bed Confined? ☐ House confined? ☐ Hospital confined? ☐

3. A. DIAGNOSIS

B. HOW DOES THIS CONDITION PREVENT THE CLAIMANT FROM WORKING?

4. TREATMENT

(a) Date of first visit .... Mo. ________ Day ________ 19 ____

(b) Date of last visit .... Mo. ________ Day ________ 19 ____

(c) Frequency of visits .... Weekly ☐ Monthly ☐ Other ____________

(d) When did you last examine the patient? .... Mo. ________ Day ________ 19 ____

5. PROGRESS

Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

6. EXTENT OF DISABILITY

		FOR ANY OCCUPATION	FOR HIS REGULAR OCCUPATION
(a) Is patient now totally disabled?		Yes ☐ No ☐	Yes ☐ No ☐
(b) If no, when was patient able to go to work?		Mo. ____ Day ____ 19 __	Mo. ____ Day ____ 19 __
(c) If yes, when do you think patient will be able to resume any work?	Approx. Date	Mo. ____ Day ____ 19 __	Mo. ____ Day ____ 19 __
	Indefinite		
	Never		

(d) If yes, is patient a suitable candidate for a rehabilitation program? Yes ☐ No ☐

DATE	SIGNATURE (Attending Physician)	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

FOR CLAIM SERVICE, CALL TOLL FREE 1-800-243-6631

EMPLOYEE'S STATEMENT

1. IS CLAIM DUE TO AN ACCIDENT? ☐ Yes ☐ No	2. IF "YES" WHERE DID ACCIDENT OCCUR?	3. DATE OF ACCIDENT
4. DESCRIBE ACCIDENT:		
5. IS CLAIM DUE TO A SICKNESS? ☐ Yes ☐ No	6. STATE NATURE OF SICKNESS	7. WHEN DID IT BEGIN?
8. IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? ☐ Yes ☐ No		

9. PLEASE DESCRIBE YOUR JOB DUTIES ______

10. HAVE YOU SUFFERED FROM THIS SAME ILLNESS BEFORE? ______ IF YES, GIVE DATES ______

11. ON WHAT DATE WERE YOU FIRST TREATED BY A PHYSICIAN FOR THIS SICKNESS OR INJURY?

12. NAME AND ADDRESS OF YOUR CURRENT PHYSICIAN ______

13.WERE YOU HOSPITALIZED? ______ GIVE DATES OF CONFINEMENT FROM ______ TO ______

14. NAME AND ADDRESS OF HOSPITAL ______

15. HAS ANY OTHER PHYSICIAN EVER TREATED YOU FOR THIS ACCIDENT OR SICKNESS? IF SO, WHEN? ______

16. PHYSICIAN'S NAME AND ADDRESS ______

17. ON WHAT DATE WERE YOU FIRST PREVENTED FROM WORKING BECAUSE OF THIS SICKNESS OR INJURY ______

18. IF YOU ARE NOW WORKING, ON WHAT DATE WERE YOU FIRST ABLE TO DO ANY PART OF YOUR JOB? ______

19. IF DUE TO TOTAL DISABILITY YOU ARE UNABLE TO WORK AT THIS TIME, WHEN DO YOU EXPECT TO RETURN? ______

20. HAVE YOU APPLIED FOR SOCIAL SECURITY? ______ APPROVED? ______

21. HOW DOES YOUR CONDITION PREVENT YOU FROM WORKING? ______

DATE ______ INSURED PERSON (SIGNATURE) ______

Indiana Law requires this notice to appear on this form -

A person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

EMPLOYER'S STATEMENT

1. EMPLOYEE'S NAME ______ DATE OF BIRTH ______ SOCIAL SECURITY NO. ______

2. OCCUPATION (DESCRIBE DUTIES) ______

3. DATE EMPLOYED ______ 19____ EFFECTIVE DATE OF INSURANCE ______ 19____

4. WAS EVIDENCE OF INSURABILITY REQUIRED? ______ AMOUNT OF INSURANCE $ ______

5. EMPLOYEE'S INSURANCE CLASSIFICATION ______ ANNUAL SALARY IF INSURANCE IS BASED ON SALARY ______

6. DATE LAST PREMIUM PAYMENT WAS MADE FOR EMPLOYEE ______

7. PRESENT STATUS OF EMPLOYEE ______ ☐ ACTIVE ☐ RETIRED ☐ LAY-OFF ☐ LEAVE OF ABSENCE ☐ OTHER

   EXPLAIN GIVING DATES OF ANY CHANGE OF STATUS ______

8. AVERAGE HOURS WORKED PER WEEK PRIOR TO ONSET OF DISABILITY ______

9. DATE EMPLOYEE LAST WORKED ______ HOUR ______ ☐ A.M. ☐ P.M.

10. REASON FOR STOPPING WORK ______

11. NATURE OF EMPLOYEE'S DISABILITY ______

12. IN YOUR OPINION DOES THIS CONDITION PREVENT THIS EMPLOYEE FROM: ______

    A. PERFORMING ALL THE DUTIES OF HIS REGULAR OCCUPATION ☐ YES ☐ NO

    B. PERFORMING AT ANY OTHER OCCUPATION ☐ YES ☐ NO

    C. HOW DOES THIS CONDITION PREVENT HIM FROM DOING THE ABOVE? ______

13. CAN PRESENT JOB BE MODIFIED TO ALLOW CLAIMANT TO WORK? ______

WE HEREBY CERTIFY THAT THE EMPLOYEE DESCRIBED HEREIN IS INSURED AS STATED AND THAT THIS CLAIM IS FULL AND TRUE TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

POLICYHOLDER ______ POLICY NO. ______ PHONE NO. ______

ADDRESS ______

CITY ______ STATE ______ ZIP CODE ______

BY ______ TITLE ______ DATE ______