DISABILITY CLAIM FORM

American Modern Life Insurance Company

PO Box 64270, St. Paul, MN 55164-0270
Phone 1-888-672-6850 Fax 513-947-4044

***CREDITOR*: COMPLETE THIS SECTION**
MONTHLY OUTSTANDING BALANCE ACCOUNTS PLEASE INCLUDE LOAN HISTORY

NAME OF INSURED:____

LOAN ACCOUNT #:_______________ EFFECTIVE DATE OF LOAN:_________ ORIGINAL LOAN AMOUNT:$___________

☐ HOME EQUITY ☐ OPEN END ☐ CLOSED END ☐ APR ______% ☐ FIXED ☐ VARIABLE

☐ SINGLE PREMIUM/CERTIFICATE #:__________________________________ MONTHLYPAYMENT: $_______________

NAME OF CREDITOR: ____

ADDRESS: ______________________________________ CITY: _________________ STATE: ________ ZIP:_____________

REPRESENTATIVE SIGNATURE: ______________________________DATE: _____________TELEPHONE (___)___________

(Please Print Name of Representative)____

***STATEMENT OF INSURED*: COMPLETE IN FULL**

1. FULL NAME **(please print):______________________________**
2. STREET:_____________________________ CITY:____________________ STATE:________ ZIP CODE:_____________
3. TELEPHONE:(   )__________ BIRTH DATE:_________ AGE:_____ SEX:_____ WEIGHT:______ HEIGHT:_________
4. CURRENT EMPLOYER:____ POSITION/JOB TITLE:___________________

   MAILING ADDRESS:__________________________ CITY:______________________ STATE:_______ ZIP:____________
   TELEPHONE NUMBER (   ) ___________________________ FAX NUMBER (   ) ___________________________
5. EXACT DAY LAST WORKED: MONTH_________ DAY_________ YEAR________ A.M.__________ P.M.__________
6. EMPLOYER (AT TIME LOAN WAS TAKEN OUT)____

   ADDRESS OF HUMAN RESOURCES:______________________________ CITY: ___________STATE:_____ZIP:_________
   TELEPHONE NUMBER (____)_______________________________ FAX NUMBER (_____)_________________________
7. DESCRIBE EXACT NATURE OF ILLNESS, INJURY OR ACCIDENT: ____

   ____

   HAVE YOU EVER HAD THE SAME/SIMILAR KIND OF ILLNESS/INJURY BEFORE? YES ☐ NO ☐
   IF YES, WHEN? MO.: ______ DAY: _____ YEAR: ______ NAME OF PHYSICIAN TREATING_________________________
8. IF ACCIDENT, DATE OF ACCIDENT: ____

   WAS THIS COVERED BY WORKER'S COMPENSATION? IF SO, CASE # ___________________________________
   PLACE OF ACCIDENT: ___________________________ DATE: ____________________ APPROX. TIME: ______________
   HOW DID IT HAPPEN? ____
9. PHYSICIAN(S) TREATING YOU FOR THIS CONDITION: _____________________ TELEPHONE: (____)________________

   MAILING ADDRESS: ____________________________ CITY: _________________ STATE:_______ ZIP CODE: ________
   (If more than one please attach a list including physician's name, address and telephone)
10. FAMILY PHYSICIAN: ______________________________________ TELEPHONE: ________________________________

    MAILING ADDRESS: ___________________________ CITY: ____________________ STATE:_____ ZIP CODE: _______
11. DATES OF TOTAL DISABILITY: FROM:______________ TO:__________________ **(UNABLE TO DO ANY WORK)**
12. HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO DATE:_______________ LIGHT DUTY? ☐ YES ☐ NO
13. IF HOSPITALIZED, GIVE NAME/ADDRESS OF HOSPITAL AND DATES YOU WERE CONFINED:___________________

    ____

    ____

I hereby authorize any employer, hospital, physician, or other person, to furnish to American Modern Life Insurance Company, any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and any and all information with respect to employment and/or employment history. A photocopy of this authorization shall be considered as effective and valid as the original. I know that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization shall remain valid for the duration of my claim.

INSURED SIGNATURE: ____ DATE:__________________________

(Please sign in ink)

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

ATTENDING PHYSICIAN COMPLETE THIS SECTION *(Please Print)*

PATIENT'S FULL NAME: ______________________ **DATE OF BIRTH:**______________

1. **DIAGNOSIS/CONDITION CAUSING PRESENT DISABILITY**: ______________________
______________________ INCLUDE ICD-9 CODE(S)______________
   Date symptoms first appeared: ______________________
   Date patient first consulted: ______________________
   Date accident happened: ______________ **Place:**______________
   Date first placed on disability by you:______________________
   Describe nature of accident and injuries:______________________
   ____

2. IS THIS A REGULAR PATIENT OF YOURS? ☐ YES ☐ NO 3. WAS THIS PATIENT REFERRED TO YOU? ☐ YES ☐ NO
   IF YES, WHEN: MO. ________ DAY ________ YEAR: ________
   IF YES: NAME OF REFERRING PHYSICIAN: ______________TELEPHONE (____)__________
   ADDRESS:______________ CITY: ____________ STATE: ________ ZIP CODE: _______

4. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

5. IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO
   ESTIMATED DELIVERY DATE: ______________ VAGINAL OR C-SECTION **(circle one)**

6. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐YES ☐ NO
   IF YES: DATE(S): ______________ **TREATMENT**: ______________

7. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION: ______________
____

8. WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO ______ INPATIENT ______ OUTPATIENT ______ ER
   IF YES:DATE(S): FROM: ________ THRU: ________ NAME OF HOSPITAL: ______________
   ADDRESS: ______________ CITY: ____________ STATE: ________ ZIP CODE: ________

9. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY, DESCRIBE FULLY: ______________
____
   DATE PERFORMED: ______________________

10. GIVE DATES OF ALL OTHER MEDICAL TREATMENT, ADVICE OR CONSULTATION PROVIDED GIVEN FOR THE PRIMARY DIAGNOSIS LISTED ABOVE DURING THE PAST TWO YEARS: ______________
____

11. LIST ALL MEDICATIONS/DOSAGES PRESCRIBED FOR PATIENT: INCLUDING THE PRIMARY DIAGNOSIS
    1. MEDICATION: ______________________
    2. FREQUENCY: ______________________
    3. DOSAGE: ______________________

12. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
    When will patient be seen again? ______________ If no, give date of release: ______________

13. HAS PATIENT BEEN REFERRED TO ANOTHER PHYSICIAN? ☐ YES ☐ NO
    IF YES, PHYSICIAN'S NAME/ADDRESS/TELEPHONE NUMBER:______________________
    ____

14. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED **(unable to work):**
    FROM: MO. ______ DAY ______ YEAR ______ **THRU:** MO. ______ DAY ______ YEAR ______

15. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED FROM WORK: **(Need Actual Date)**
    FROM: MO. ______ DAY ______ YEAR ______ **THRU:** MO. ______ DAY ______ YEAR ______

______________ ______________ ______________
SIGNATURE (ATTENDING PHYSICIAN) **DEGREE** **DATE**

______________ ______________ (_____)______________
PRINT OR TYPE PHYSICIAN'S NAME **TAX ID #** **TELEPHONE**

______________ ______________ ________ ________ ______________
ADDRESS **CITY** **STATE** **ZIP CODE** **FAX NUMBER**