



**NATIONAL BENEFIT LIFE
INSURANCE COMPANY**

PO BOX 1946, Long Island City, N.Y. 11101
TEL 1-800-535-2710 ■ FAX 1-800-584-9303

Date Form Issued _____
Name _____
Claim # _____
Policy # _____
Change of address see back of form

To prevent delay of payment of Disability Benefits, this form must be fully completed, signed and returned to the insurance company by _____

CLAIMANT'S STATEMENT

Are you presently hospitalized? YES NO If YES from _____
DATE
What now prevents you from returning to employment? _____
Have you returned to work? YES NO If YES _____
DATE
Are you able to work? YES NO If YES _____
DATE
Are you collecting Unemployment Insurance? YES NO If YES from _____
DATE
Signed _____ Date _____

PLEASE HAVE YOUR DOCTOR COMPLETE AND SIGN THE FOLLOWING STATEMENT

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name _____ Dates of Hospitalization-from _____ to _____
Nature of sickness or injury (Describe complications,if any) _____

Date of first treatment _____ Date of most recent treatment _____ Frequency _____
Nature of treatment (Describe) _____
Date your care was, or will be terminated _____
Patient has been totally disabled (unable to work) from _____ to _____
If still disabled, date when patient should be able to return to work _____
Check One: Full Time Part Time

MATERNITY PATIENT ONLY: EDC DATE: _____ DELIVERY DATE _____ TYPE _____

Remarks: _____

PHONE NO. _____ SIGNED _____ DEGREE _____
DATE _____ ADDRESS _____

BENEFITS WILL BE DELAYED IF THIS FORM IS NOT SIGNED BY THE PHYSICIAN