NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800-222-2062

Waiver of Premium

REPORT OF CLAIM - CLAIMANT'S DISABILITY STATEMENT

Full Name of Claimant: _____Policy Number: _____

Address: _____Apt No: _____

City: _____State: _____Zip Code: _____

Date of Birth _____ Occupation: _____

Employer: _____

Business Address: _____
Street City State Zip Code

Last full day worked: _____Date Illness or Injury began: _____

Describe exact nature of illness or injury: _____

_____

IF DISABILITY WAS DUE TO INJURY:

(a) Date of injury: _____20_____ (b) Place: _____

(c) Were you engaged in your regular occupation? _____

(d) Explain how injury happened: _____

_____

Have you ever had the same kind of ILLNESS OR INJURY before? _____

If so, when? _____ by whom were you treated? _____

Has your present doctor or any other doctor treated you during the past 5 years? Yes_____ No_____

If so, Who? _____ When? _____

For what? _____

If still disabled, what are your present activities? _____

Date first physically able to resume any part of your duties: _____20 _____ AM _____PM_____

Date first physically able to resume all of your duties: _____ 20_____AM _____PM_____

If still disabled, when do you expect to return to work? _____ 20_____ AM _____PM_____

If you were hospitalized, give the name and address of the hospital: _____
Name of Hospital

_____
Address City State Zip Code

Date Admitted: _____20_____ Date Discharged: _____20_____

Have you any other Accident or Sickness Insurance? Yes_____ No_____

If yes, list Names of Companies or Associations and amounts in each: _____

I have checked the above answers, and they are correct.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has information concerning case history records, laboratory reports, diagnoses, x-rays and other data covering this and/or previous injuries and/or illnesses to give National Benefit Life Insurance Company or its representatives any such information. A copy of this authorization shall be deemed as effective and valid as the original.

The following statement is made in accordance with Insurance Laws: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Claimant: _____Tel#_____Date:_____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name:	Age:
Nature of sickness or injury. (Describe complications if any) Enter diagnosis (ICD-9 Code(s)) _____ Is the condition due to pregnancy? Is the condition due to injury or sickness arising out of patient's employment?	_____ Yes ☐ No ☐ Yes ☐ No ☐
If fracture or dislocation, state whether complete or incomplete. If fracture of long bones, state type and location. Was it confirmed by X-ray?	_____ Yes ☐ No ☐
When did symptoms first appear or accident happened?	Month/ Day/ Year:
When did patient first consult you for this disability?	Month/ Day/ Year:
Has patient ever had same or similar condition? (If "YES" state when and describe)	Yes ☐ No ☐
Describe any other disease or infirmity affecting present condition.	
Nature of surgical procedure, if any, give date(s) performed. CPT Code(s):	Month/ Day/ Year:
Give all dates of treatment from the onset of this disability to present. What is the date of disability? _____	Office_____ Home_____ Hospital_____
Is patient still under your care for this condition? If discharged, give date.	Yes ☐ No ☐ Date:_____
If patient hospitalized, give name and address of hospital:	_____ Hospital Name City State Date admitted: Date discharged:
How long was or will patient be continuously and totally disabled (unable to work)?	Date from: Date to:
How long was or will patient be partially disabled?	Date from: Date to:
Was patient confined to the house? (If "Yes" give dates)	Yes ☐ No ☐ Date from: Date to:
What is your prognosis?	
Give names and addresses of other physicians consulted by the patient	

Date: _____ _____ MD Specialty: _____
(Attending Physician Print Name)

Telephone # :( ) _____ Signature: _____
(Attending Physician)

Street: _____ City: _____State: _____ Zip Code: _____

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PLEASE RETURN THIS FORM WITH YOUR CLAIM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

For Use and Disclosure of Protected Health Information

By my signature below:

(1) I authorize National Benefit Life Insurance Company, its affiliates (collectively the "Company"), reinsurers, and authorized representatives, including agents, insurance support organizations and service providers to receive my health information;
(2) I acknowledge that health information may include information about prescription histories, the diagnosis, treatment and prognosis of any physical or mental condition and the use of drugs or alcohol, but not psychotherapy notes;
(3) I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, pharmacy, pharmacy benefit manager, insurance company, clearinghouse, or other entity or person ("Providers") to disclose my health information;
(4) I acknowledge that this Authorization may be relied upon to determine my eligibility for insurance, to obtain reinsurance, to administer any claim for insurance benefits or for any other business purpose not otherwise prohibited, including but not limited to any activities related to coverage or benefits or to support the business operations of the Company;
(5) I acknowledge that this Authorization expires two (2) years from the date it is signed;
(6) I acknowledge that I may revoke this Authorization at any time by sending written notice to the Company's address, however, any revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits or the policy itself;
(7) I acknowledge that if I refuse to sign this Authorization, a Provider may not refuse to provide treatment or payment for health care services, however, the Company may not be able to process this application or, if coverage is issued, process this claim or make any benefit payments;
(8) I acknowledge that information disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy of health information; and
(9) I acknowledge that a photographic copy of this Authorization, including a photographic or electronic copy of my signature, is valid as the original and I may receive a copy of this Authorization after it is signed.

Insured: _____Policy Number: _____

Signature of Claimant: _____Date: _____