NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3343 • 800-222-2062

CLAIMANT'S SUPPLEMENTARY OR FINAL DISABILITY STATEMENT

INSTRUCTIONS: THIS FORM IS TO BE COMPLETED AND RETURNED BY: _____

Claimant's Name _____Policy No. _____Claim No._____

Date illness began or accident occurred: _____

Last full day worked _____Date returned to work: _____

If presently employed, for whom do you work? _____

_____

If disabled, when do you expect to return to work? _____

What are your present daily activities? _____

Between what dates were you confined to the house?

From: _____To:_____

If confined to the hospital, which one _____

From: _____To:_____

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.

Date: _____Claimant's Signature: _____

Street Address: _____Apt No. :_____

City_____ State _____ Zip _____

Telephone No.:_____

NOTE: PAYMENT OF BENEFITS MAY BE DELAYED IF BOTH SIDES OF THIS FORM ARE NOT COMPLETED IN FULL AND RETURNED TO THE COMPANY IN ACCORDANCE WITH THE INSTRUCTIONS SHOWN AT THE TOP OF THIS PAGE.

REVERSE SIDE MUST BE COMPLETED IN FULL BY ATTENDING PHYSICIAN

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name	
1. Nature of sickness or injury. (Describe complications if any) Enter diagnosis(ICD-10 Code(s))	
2. Describe any other disease or infirmity affecting present condition. Enter diagnosis(ICD-10 Code(s))	
3. Give all dates of treatment after _____to the present. If, none give reason in Remark Box.	Office _____ Home_____ Hospital_____
4. Is patient still under your care for this condition? If discharged, give date.	Yes ☐ No ☐ Date:_____
5. How long was or will patient be continuously & totally disabled? Indicate date patient can return to work: _____	From:_____To:_____
6. Is patient partially disabled? _____ If yes, give dates of partially disability. Indicate date patient can return to work: _____	From:_____To:_____
7. Was patient confined in hospital? (If "Yes" give dates and name) Was surgery performed? _____ Dates(s) _____ CPT Code(s) _____	Yes ☐ No ☐ Hospital Name: _____ From:_____To:_____
8. Progress	☐ Recovered ☐ Unimproved ☐ Improved ☐ Retrogressed
REMARKS:	

Date: _____ _____ MD Specialty _____

(Print Physician's Name)

Telephone# ( ) _____ Signature: _____

(Attending Physician's Name)

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: _____