



DISABILITY CLAIM FORM
AMERICAN MODERN LIFE INSURANCE COMPANY
 P.O. BOX 5323, CINCINNATI, OHIO 45201-5323
 1-888-672-6850 EXT. 2110

CREDITOR: COMPLETE THIS SECTION

MONTHLY OUTSTANDING BALANCE ACCOUNTS PLEASE INCLUDE LOAN HISTORY

NAME OF INSURED: _____ SOCIAL SECURITY #: _____ - _____ - _____
 LOAN ACCOUNT #: _____ EFFECTIVE DATE OF LOAN: _____ ORIGINAL LOAN AMOUNT: \$ _____
 HOME EQUITY OPEN END CLOSED END APR _____% FIXED VARIABLE
 SINGLE PREMIUM/CERTIFICATE #: _____ MONTHLY PAYMENT: \$ _____
 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): _____ SOCIAL SECURITY # _____ - _____ - _____
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: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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**