PEKIN INSURANCE

PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET / PEKIN, ILLINOIS 61558

CLAIM NO. _____

INSURED'S SUPPLEMENTAL STATEMENT

THIS FORM SHOULD BE COMPLETED AND RETURNED FOR PAYMENT ON _____ OR AT THE END OF THE PERIOD OF DISABILITY, WHICHEVER OCCURS FIRST.

Insured	**Policy/Cert. #**
1. Last date worked	
2. Nature of sickness or injury. (Explain in detail.)	
3. Are you receiving state Unemployment Benefits?	❑ yes ❑ no Date began Date ended
4. When were you last treated by a doctor? Have you been released from doctor's care?	Date _____ ❑ yes ❑ no If yes, give date
5. Have you resumed any work? Was this any part of your regular duties?	❑ yes ❑ no If yes, give date _____ ❑ yes ❑ no Date of return to regular duties:
6. If you have not returned to work, when do you expect to?	Date

Indiana Claims: 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.

Ohio Claims: 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 false or deceptive statement is guilty of insurance fraud.

I hereby certify that the answers given above are full and true. Any information not reported, or information reported that is not true, may be used to deny a claim and/or void coverage in accordance with the provisions of the Department of Insurance. It is agreed that the furnishing of this form or its acceptance by the company as proof does not constitute an admission of any liability, nor a waiver of any of the conditions of the insurance contract.

Pekin Life Insurance Company or its representatives are hereby authorized to examine and secure copies of any medical, employment, governmental, insurance company or other records or information. A copy of this authorization shall be considered as valid as the original. Valid for the duration of this claim. I may receive a copy.

_____ , _____ _____ _____

Date | Signature of Insured | Street Address | City or Town | State | Zip

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT
(To be completed entirely by Doctor's Office)

Patient's Name _____ Date Disability Began _____

Date of Last Treatment _____ Date of Next Scheduled Appt. _____

I hereby certify that this patient:

❑ Was released to return to full work on _____

❑ Was released to return to partial work on _____ List Restrictions if any _____

_____

❑ Continues to be TOTALLY DISABLED FROM PERFORMING ANY WORK as a result of (indicate condition)

_____

and is still being regularly treated by me.

Probable further total disability should not exceed 1 2 3 4 5 6 7 8 9 weeks ❑ months ❑

Date _____ Signature _____ Phone # (____) _____

(Attending Physician) (Degree)

Federal Tax I.D. Number _____ Fax # (____) _____

Street Address _____ City _____ State _____ Zip Code _____