Reset

PEKIN LIFE INSURANCE COMPANY
Attn: Life Claim Department
P.O. Box 1587 • Pekin, Illinois 61555
www.pekininsurance.com • phone: 800/371-9622 • fax: 309/346-8265

DISABILITY STATEMENT OF THE INSURED

INSURED INFORMATION

Policy Number:_____ Insured's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth:_____ SSN: _____ Telephone Number:_____

ASSIGNEE INFORMATION (Only complete this section if you have a mortgage policy that begins with "SA".)

Creditor:_____ Telephone Number:_____

Creditor's Address: _____ City: _____ State: _____ Zip: _____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Address:_____

Occupation: _____ Has your employment terminated?_____

Substantial Duties (Be specific):_____

_____

DESCRIBE DISABILITY

Describe the accident or illness fully:_____

_____

Date accident or illness began:_____ Date symptoms first appeared: _____

Date first treated: _____ Dates of medical treatment:_____

Date of next doctor's appointment: _____ If hospitalized, Admit Date: _____ Discharge Date:_____

Full name and address of hospital: _____

_____

Name and address of first physician seen: _____

Name and address of family doctor:_____

Names and addresses of all treating physicians and/or hospitals:_____

_____

Have you ever had the same or similar condition in the past? _____ If yes, please list the names and addresses of treating physicians and/or hospitals:_____

TOTAL DISABILITY

Last date worked:_____ First date of disability: _____ Date you returned to work: _____

If you have not returned to work, when is your anticipated return date? _____ Dates you were unable to perform all of the substantial and material duties of your occupation due to this illness or injury: From_____ To _____

PARTIAL DISABILITY

Have you worked any full or partial days since your disability began?_____

List the duties of your job you could not perform during any period of time you were partially disabled:_____

_____

Dates of partial disability: From _____ To_____

DISABILITY STATEMENT OF THE INSURED (Continued)

UNEMPLOYMENT BENEFITS

Have you applied for or are you receiving unemployment benefits? _____

First date eligible?_____ Date first check received? _____

WORKER'S COMPENSATION

Is this condition the result of a work related incident?_____

Have you filed or are you going to file a worker's compensation claim?_____

OTHER INCOME (If you have a mortgage policy that begins with "SA", you may skip this section.)

Name, address and phone number of any other disability carrier: _____

_____

Amount of benefit received from other disability carrier: _____

Average annual salary for the 2 years prior to your disability:_____

Have you applied for or are you receiving Social Security Disability? ____ Please include a copy of your reward or denial.

Identify any other income sources and amount of income for which you are receiving or may be entitled to receive during this disability. _____

AUTHORIZATION

PEKIN LIFE INSURANCE COMPANY or its representatives are hereby authorized to examine and secure copies of any medical records, including information relating to mental illness, and drug and alcohol use, employment records, governmental records, records of other insurance companies, or other records or information. A copy of this authorization shall be considered as valid as the original.

I understand that such information will be used by Pekin Life insurance Company for the purpose of evaluating my claim for insurance benefits. I or any authorized representative will receive a copy of this authorization upon request. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. Pekin Life Insurance Company may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. This authorization is valid for the date signed for the duration of the claim. You may revoke this authorization at any time by signing and dating the revocation section and returning it to this office at the address listed above. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

SIGNATURE

I hereby certify that the answers given on pages 1 and 2 of this statement are full and true:

Insured's Signature: _____ Date: _____

AUTHORIZATION REVOCATION (Only sign here if you wish to revoke your authorization.)

Insured's Signature: _____ Date: _____

Indiana Claims: Submission of a false insurance claim with intent to defraud an insurer is a Class D 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.

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ATTENDING PHYSICIAN'S STATEMENT

INSURED INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

DIAGNOSIS AND TREATMENT

1. Diagnosis and concurrent conditions _____

   _____

2. (a). Is condition due to injury or sickness arising out of patient's employment? ❑ yes ❑ no

   If yes, explain _____

   (b). Is condition due to pregnancy? ❑ yes ❑ no If yes, approximate date pregnancy began _____

3. (a). Date of accident or first symptoms of illness _____

   (b). Date patient first consulted you for this condition _____

   (c). Give all other dates of treatment in office _____

   (d). If patient was hospitalized, name and address of hospital _____

   _____

   (e). Dates hospitalized _____

   (f). Nature of surgical procedure, if any _____ Date performed _____

4. Has patient ever had same or similar condition? ❑ yes ❑ no If yes, when _____

5. Is patient still under your care for this condition? ❑ yes ❑ no If no, date last treated _____

DISABILITY CERTIFICATION

6. (a). Dates patient was totally disabled (Unable to work): From _____ To _____

   (b). Dates patient was partially disabled: From _____ To _____ w/ restrictions of: _____

   _____

   (c). If disability continuing, when will patient be able to return to work? _____

PHYSICIAN'S SIGNATURE

_____ _____ _____
Attending Physician – Signature Degree Date Phone Number

_____ _____ _____
Attending Physician – Print Federal Tax I.D. Number Fax Number

Street Address: _____ City: _____ State: _____ Zip: _____

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.

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EMPLOYER'S REPORT

INSURED INFORMATION

Name of Employee: _____ Policy No./Certificate No.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

EMPLOYMENT INFORMATION (To be completed by the employer or timekeeper.)

1. Date first employed by your company _____
2. On what date did accident occur or sickness commence? _____ hour _____ ❑ a.m. ❑ p.m.
3. On what date did employee stop work? _____ hour _____ ❑ a.m. ❑ p.m.
4. What is employee's occupation? _____

   What are employee's usual duties? _____
5. Full time employee? ❑ yes ❑ no

   Within the last two years, has employee ever worked less than 30 hours per week (other than vacation)? ❑ yes ❑ no

   If yes, please list dates _____

   Part time employee? ❑ yes ❑ no If part time, how many hours worked per week? _____
6. On what date did employee first return to work? _____ hour _____ ❑ a.m. ❑ p.m.
7. If partially disabled, what duties of employee's regular job was he/she able to perform? _____

   _____
8. On what date did employee return to full duty? _____ hour _____ ❑ a.m. ❑ p.m.
9. If still disabled, is position being held for employee? ❑ yes ❑ no

SIGNATURE

Name of Employer: _____ Telephone No.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Print Name: _____ Official Position: _____

Signature: _____ Date: _____

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