Reset

PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET, PEKIN, ILLINOIS 61558
Phone: 309-346-1161 – Financial Products Claim Department • Fax: 309-478-2093

Instruction to creditor (Complete this section before giving form to insured)

Name of Insured in full _____

Insured's Policy/Certificate No. _____ Loan Account No. _____ Term of Loan _____

Date of Loan _____ Due Date of 1st Loan Payment _____ Creditor Code # _____

Creditor _____

Creditor's Address _____ City _____ State _____ Zip _____

Completed by _____ Title _____ Date _____ Phone No. _____

IF MOB: Attach Amortization schedule as of last advance, prior to disability date

STATEMENT OF THE INSURED

Enter the last 4 digits of your SS #

*Claim form should be completed **after waiting period** is fulfilled.* **Attach Loan Payment Coupon or Statement.**

Insured's Name _____ Date of Birth _____ Tel. No. _____

Address _____ City _____ State _____ Zip _____

Employer's Names and Addresses (If more than one, list all) _____ Occupations _____

Duties

Employer(s) when you purchased this insurance. (Name, Address, & Phone Number) _____

1. Describe injury or sickness fully. _____
2. If accident, give details. Date _____ ❑ AM ❑ PM Where? _____
   How? _____
3. When were first symptoms noticed? Date _____ Describe _____
4. (a). Name and address of first doctor consulted _____
   (b). Date Consulted _____
   (c). Name and address of hospital _____
   Dates confined From _____ To _____
5. Name and address of family doctor _____
6. Names and addresses of all other doctors consulted

NAME	ADDRESS	DATE

7. Has same or similar condition occurred before? ❑ Yes ❑ No If "yes", when? _____
   Name and address of doctor consulted _____
8. (a). Last date worked _____ (b). First date of disability _____
9. Are you applying for or receiving state unemployment benefits ❑ Yes ❑ No Date began _____ Date ended _____
10. Date you returned to any work _____ Was this any part of your regular duties? ❑ Yes ❑ No
11. If you have not returned to work, when do you expect to? _____

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.

Arkansas and Louisiana Claims: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 of 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 of this authorization upon request.

_____ , _____ _____

DATE SIGNATURE OF INSURED

_____

STREET ADDRESS CITY OR TOWN STATE ZIP

PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET, PEKIN, ILLINOIS 61558
CLAIM DIVISION

DISABILITY

ATTENDING PHYSICIAN'S STATEMENT – HEALTH INSURANCE CLAIM - GROUP OR INDIVIDUAL

(To be completed entirely by Doctor's Office)

PATIENT'S NAME _____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

_____

1. Diagnosis and concurrent conditions. _____

2. In the past three years, has patient been taken off work, more than five consecutive days, due to substance abuse, back disorder, mental or nervous disorder?
   ❑ yes ❑ no If "yes", dates _____

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

   (b). 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 _____

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

   (b). Dates patient was partially disabled From _____ To _____

   List restrictions: _____

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

_____ _____ _____

SIGNATURE (ATTENDING PHYSICIAN) DEGREE DATE PHONE NUMBER

_____ _____ _____

ATTENDING PHYSICIAN'S NAME (PRINT) FEDERAL TAX I.D. NUMBER FAX NUMBER

_____

STREET ADDRESS CITY OR TOWN STATE ZIP CODE

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EMPLOYER'S REPORT

CLAIM DIVISION

Policy No./Certificate No. _____

If **SELF EMPLOYED** – Please contact our office at 309-346-1161 – Financial Product Claim Department.

To be completed by the employer, timekeeper or superior officer under whom employee was working when disabled.

Name of Employee _____ Last 4 Digits of Social Security # ☐

1. Date first employed by your company _____
2. On what date did accident occur or sickness commence?_____ hour _____ ❑ AM ❑ PM
3. On what date did employee stop work? _____ hour _____ ❑ AM ❑ PM
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 25 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. In the past three years, has employee missed more then five consecutive days of work due to substance abuse, back disorder, mental or nervous disorder? ❑ yes ❑ no If "yes", dates: _____
7. On what date did employee first return to work? _____ hour _____ ❑ AM ❑ PM
8. If partially disabled, what duties of employee's regular job was he/she able to perform? _____
9. On what date did employee return to full duty? _____ hour _____ ❑ AM ❑ PM
10. If still disabled, is position being held for employee? ❑ yes ❑ no

Name of Employer _____ Signature _____

Address _____ Official Position _____

City _____ State _____ Zip _____ Date _____

Telephone Number ( ) _____ Fax Number ( )_____

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