

**Central United Life Insurance Company
Investors Consolidated Insurance Company
Disability Claim Form**

Warning: 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 civil fines and criminal penalties.

TO BE COMPLETED BY THE INSURED:

Policy No. _____

1. Name of Insured _____ Date of Birth _____ S.S. # _____
2. Address _____ City _____ State _____ Zip _____ Phone # () _____
3. Name of Employer _____ Address _____ City _____ State _____ Zip _____
4. Occupation _____ Duties _____
5. Date sickness began or accident occurred _____ Date you last worked _____
6. Nature of sickness or injury _____
7. Have you had the same or similar sickness before? _____ If yes, explain _____
8. If injured, how, and where did the accident occur? _____
9. First treating physician: Full name _____ Address _____ Date _____
10. Date disability began: Month _____ Day _____ Year _____ A.M. _____ P.M. _____
11. On what date did you (or do you) expect to resume any part of your work? _____

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give Central United/Investors Consolidated Insurance, or its representatives, any such information.

A photographic copy of this authorization shall be as valid as the original.

APPROVED BY: _____

DATED _____

SIGNED _____

Attending Physician

Claimant's Signature

TO BE COMPLETED BY ATTENDING PHYSICIAN: FAILURE TO PROVIDE ALL INFORMATION REQUIRED BELOW MAY DELAY PAYMENT

1. Name of Patient _____ Age _____
 2. How long have you been Insured's physician _____
 3. Nature of sickness or injury, describe complications, if any _____
 4. When did the patient first consult you for this condition? _____
 5. List all treatment for this condition _____
 6. If patient hospitalized, give name and address of hospital _____
Date admitted _____
 7. Was surgery performed? _____ If so, procedure and date performed _____
 8. Has the claimant had the same or similar illness before? _____ If yes, when? _____
 9. How Long Was Or Will Patient Be Continuously Totally Disabled? FROM _____ TO _____
 10. How Long Was Or Will Patient Be Partially Disabled? FROM _____ TO _____
 11. Was the patient referred to another doctor? _____ if so, whom? _____
 12. Confining Date _____ Thru _____ Non Confining Date _____ Thru _____
- Typewritten name of Physician _____ Address _____ Degree _____
Signature _____ Date _____ Phone No. _____

TO BE COMPLETED BY THE EMPLOYER:

1. Employer Name _____ Address _____ Zip _____
2. Employer's Phone # () _____ Workmen's Comp Claim Filed ? _____
3. Name of Compensation carrier _____
4. Between what dates did employee give up all duties: TOTAL DISABILITY FROM _____ TO _____

Date _____ Title _____ Signature _____

Form No. 701-NM

No faxed claims accepted



Central United Life Insurance Company
Investors Consolidated Insurance Company
P. O. Box 925309
Houston, TX 77292-5309

**COMPLETE AND RETURN
THIS FORM PROMPTLY**