Please check the box next to your insurance company's name.

❑ Central United Life Insurance ❑ American States

PREMIUM WAIVER
DISABILITY CLAIM FORM ADDENDUM

Instructions: Please have your Attending Physician/Doctor fill out and sign this form.

DATE_____ INSURED_____

POLICY#_____ REGULAR OCCUPATION_____

EXTENT OF DISABILITY FROM:	ANY OCCUPATION	REGULAR OCCUPATION
1) Is the patient (insured) now TOTALLY DISABLED?	_____YES _____NO	_____YES _____NO
2) If not, when is the patient able to return to work?	Date:_____	Date:_____
3) If yes, when do you think the patient (insured) will be able to return to work?	Date:_____	Date:_____
	Never:_____	Never:_____

ANY OTHER REMARKS YOU WISH TO MAKE CONCERNING THE DISABILITY
(including other occupation suitable for the patient's condition):

_____

_____

_____

_____

Doctor's Signature:_____

Date:_____

Doctor's Name, Address, and Phone Number:

_____

_____

_____