

THE MANHATTAN LIFE INSURANCE COMPANY

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

No faxed claims accepted

CLAIMANT'S STATEMENT FOR CONTINUANCE OF DISABILITY BENEFITS

Please complete the following form and have your attending physician complete the reverse side in approximately 30 days, or sooner if your disability terminates.

YOUR NAME _____ S.S. # _____ POLICY # _____

Have you attempted any employment since you became disabled? Yes No

If yes, Name of Employer _____ Address _____

Duties _____ From _____ To _____

If PRESENTLY employed, on what date did you resume work?

Part time? Month _____ Day _____ Year _____

Full time? Month _____ Day _____ Year _____

For whom do you work? _____ Address _____

What are your duties? _____

Do you believe you can continue with your work? Yes No

If now working PART TIME, how many hours _____ a day and days _____ a week?

If you are NOT presently employed:

Are you bed-confined? Yes No

Hospital-confined? Yes No

Do you believe your health is improving? Yes No

What are your present daily activities? _____

In your opinion, are you able to do some kind of work? Yes No

When do you think you might be able to return to work? _____

I hereby authorize any hospital, physician or organization to furnish The Manhattan Life Insurance Company any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records. I agree that a copy of this authorization shall be considered as effective and valid as the original

Date

Signature of Claimant

Address State Zip Code Phone Number

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

To be furnished without expense to the Company

Patient's name	Patient's Date of Birth
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- (1) Nature of sickness or injury
(Describe complications, if any)

- (2) Describe any other disease or infirmity affecting present condition.

- (3) Give date of treatments.
(Since _____) Office _____
Home _____
Hospital _____

- (4) Is patient still under your care for this condition?
If discharged, give date Yes No
Date _____

- (5) How long was or will patient be continuously totally disabled (unable to work)?
From _____ through _____

- (6) (If accident), how long was or will patient be partially disabled?
From _____ through _____

- (7) If sickness, was patient confined to the house?
(if "Yes", give dates) Yes No
From _____ through _____

REMARKS

FAILURE TO PROVIDE ALL INFORMATION BELOW MAY DELAY CLAIM PAYMENT.

Date _____ Signed _____ Degree
Attending Physician M. D.
Ph # () _____

(Street Address) (City or Town) (Zone) (State or Province)



The Manhattan Life Insurance Company
P.O. Box 2728
Houston, TX 77252-2728

**COMPLETE AND RETURN
THIS FORM PROMPTLY
Please fold in half, then fold in half
again so that the address is showing
thru the window in the enclosed
envelope**