

Life Premium Waiver
Family Life Insurance Company
Disability Claim Form – Valid for PREMIUM WAIVER only

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.

TO BE COMPLETED BY THE INSURED:

Policy No. _____

Section I

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 or reinsuring company, the Medical Information Bureau, Inc., (MIB) consumer reporting agency or employer having any record of me available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me to give to Family Life Insurance Company, its reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for benefits under an existing policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months, 180 days for HIV related information, from the date below and may be revoked at any time. The revocation of the authorization must be submitted in writing.

I declare that the preceding statements are true and complete, and that, to the best of my knowledge and belief, I have withheld no material facts from the Company.

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

Section II

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:

Section III

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 _____

No faxed claims accepted

Form No. 701-FLIC

Claims Department
P.O. Box 925309
Houston, Texas 77292-5309

**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