



Attention: Claims Department
 P.O. Box 1650
 Little Rock, Arkansas 72203-1650
 Telephone (501) 375-7200
 1-800-370-5856
 Fax (501) 235-8417

Statement of Claim Disability Income Benefits

For H.O. Use Only	
Eff	_____
PTD	_____
Benefits	_____

Instructions

1. Please type or print in blue or black ink.
2. Please make sure all questions on Employee's Statement are completed in full.
3. Authorization must be signed and currently dated.
4. Employer's & Physician's Statements on Page 2 (reverse side) must be completed.
5. Fax or mail the completed form to US Able Life.

EMPLOYEE'S STATEMENT			
Full Name (Last, First)		Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		Date of Birth	Occupation
City, State, Zip Code		Telephone Numbers Home _____ Work _____	
Claim is for <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy		Nature of Accident or Sickness	
Date of 1st Treatment	Physician or Hospital First Treated By		First Full Day of Disability
If accident, how did the accident occur? _____			
Accident Date _____ Time _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Place _____			
Names and addresses of all doctors consulted for this condition (Use separate sheet if necessary):			
Physician	Date Treated/Consulted	Address, City, State and Zip Code	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Have you ever had this or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give particulars: Date _____			
Describe _____			
Names and addresses of all doctors seen for any condition in the past five years (Use separate sheet if necessary):			
Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Authorization to Obtain Information			
In signing below, I represent that the statements and answers given are true, complete and correctly recorded. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge I have a right to a copy of this authorization upon request.			
FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.			
_____		_____	
Date		Employee's Signature	

Please have your Employer and Attending Physician complete page 2 (reverse side).

ATTENDING PHYSICIAN'S STATEMENT (APS)

**** Neither the Employee nor the Employer should complete or alter any part of the APS. ****

Patient's Full Name _____		Date of Birth _____
Diagnosis & Concurrent Conditions 1. _____ 2. _____		ICD Codes 1. _____ 2. _____
Disability is due to <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy If accident, provide how, when and where accident occurred _____ _____ _____ If Pregnancy, _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated Delivery Date _____ Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section _____ Date Symptoms First Appeared _____ Date Patient First Consulted You _____ Dates & Surgical Procedures (if any) _____ _____ _____ If hospitalized, <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Admitted _____ Date Discharged _____ Full Name of Hospital _____ Address _____ City, State, Zip Code _____ _____ Telephone # of Hospital _____		Did disability arise from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ How long was or will patient be unable to work due to disability? From _____ Through _____ Can return to work on _____ Please list all treatment dates during the month in which the disability began _____ _____ _____ Date of next doctor's appointment _____ _____ List Restrictions and Limitations _____ _____ _____ _____ Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ Describe any circumstances causing disability to be prolonged: _____ _____ _____

Physician's Signature _____		Date _____
Physician's Name (Please Print/Type) _____		Degree _____
Address _____		Telephone _____
City _____	State _____	Zip Code _____ Fax _____

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EMPLOYER'S STATEMENT

Group Policy Number _____	Employee Social Security Number _____	Date of Hire _____	Coverage Effective Date _____	Annual Salary _____
Last Day Worked Date _____ # of Hours _____	Date Returned to Work: <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____	Employee Regularly Works _____ Hours Per Week Employee Regularly Works Weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employee eligible for any of the following?				
1. Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____ per Month	Effective Date _____	Termination Date _____
2. Social Security Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____ per Month	_____	_____
3. Social Security Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____ per Month	_____	_____
4. Employer's Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____ per Month	_____	_____
5. Any Other Disability Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____ per Month	_____	_____
6. Sick Pay	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____ per Month	_____	_____
Employer Name _____		Tax ID # _____	Date _____	
Signature _____		Title _____		
Name (Please print or Type) _____			Telephone _____	
Street Address _____		City _____	State _____	Zip _____ Fax _____

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida

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.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Retain for your records.