

Disability Claim Form

MAIL PROCESSING CENTER, P.O. BOX 10546, SPRINGFIELD, MO 65808-0546 Toll-Free (888)350-1488 Fax (409) 621-3077 Email: Health.Disability&Life@AmericanNational.com

FAILURE TO COMPLETE THE ATTACHED AUTHORIZATION WILL REQUIRE THE FORM TO BE RETURNED TO YOU FOR COMPLETION.

PART 1 - TO BE COMPLETED BY THE EMPLOYEE OR CLAIMANT								
1.Claimant's Full Name and Complete Address		Telephone Number and Email Address						
2. Name of Claimant's Employer		3. Certificate Number						
4. Sex Male Female 5. Date o	f Birth	6. Status	Married	Single				
7. Explain the nature of the sickness or injury.		Was it work related? Yes No			No			
8. Date you became unable to work at your oc	ccupation because of disability:							
9. On what date were you first treated by a physician for this disability?								
10. Physician(s) consulted during present illne	ess or injury:							
Name:	Address:							
Period Treated From:		To:						
I certify that the information provided above is	s true and correct.							
Signature		Date						
Signature			Date					
PART 2 - TO BE COMPLETED BY THE CL	AIMANT'S EMPLOYER							
1.Job Title of Claimant	Date Employed	Ann	nual Salary					
2. List Job Duties:								
Prior to disability, did you consider your em	plovee able to perform:							
Sedentary Work: Lift 10 lbs. maximum a	· · · ·	cts						
Light Work: Lift 20 lbs. maximum and frequently lift/carry up to 10 lbs.								
Medium Work: Lift 50 lbs. maximum and frequently lift/carry up to 25 lbs.								
Heavy Work: Lift 100 lbs. maximum and frequently lift/carry up to 50 lbs. Very Heavy Work: Lift in excess of 100 lbs. and frequently lift/carry 50 lbs.								
How has Employee's disability interfered with the performance of his/her job?								
4. How has Employee's disability interfered w	in the performance of his/her job) (
5. Date last worked								
6. When did employee return to work?								
7. If not back at work, when do you expect the employee to return?								
7. Il not back at work, when do you expect the	employee to return:							
Signature			Date					
Print Name and Title		Email						
Address		Phone						
		. 110110						

ATTENDING PHYSICIAN'S STATEMENT FOR DISABILITY THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Name of Patient:				Date of Birth:			
1. Diagnosis (include	ICD10 code)			2. Dat	te Disability Commenced		
3. Present Condition (a) Subjective sym (b) Objective finding	ptoms	current X-rays, E.K.G's.	, or any other	special te	ests.		
(c) Is Patient:	Is Patient: Ambulatory? Bed Confined? House Confine		Confined?	ed? Hospital Confined?			
4. Prognosis							
5. History							
a) When did symptom b) Data you advised w	* *						
(c) Date you advised you(d) Has the Patient eve(d) If "Yes", state when	r had the same or simi	-		Yes	No No		
d) Is condition primaril	y related to the Patien	t's employment?		Yes	No		
·							
e) When did Patient fiif) Was this Patient ref	rst consult you for this ferred to you by anothe			Yes	 No		
	name and address of			165	110		
. Treatment							
a) Dates of treatmentb) Frequency of visits:		Weekly	Monthly	Other	r, Specify:		
c) Has Patient undergo	one surgery?	•	Wioritally	Yes	No		
	e, procedure and result			Yes	No		
ii No , do you ex	pect surgery to be perf If "Yes", give date ar			163	INO		
7. Extent of Disabili	•	•	v diaablad di	ua ta thia	o condition		
•		tient was continuously	y disabled di	ue to triis	s condition.		
a) Totally Disabled:b) Partially Disabled:	From to						
,		——— eleased to return to wor	k?				
Restriction and L	•						
. Restriction and I							
	t to endorse checks ar No	nd direct the use of the p	proceeds with	a clear u	nderstanding of his/her acts?		
11. Remarks: (any c	omments relative to cu	rrent disability not embr	aced by abov	e questior	ns)		
Signature of A	Attending Physician				Date		
hysician Name			Email				
Address			Phone	<u> </u>			
			Fax				

FRAUD WARNING NOTICES

For your protection, certain states requires the following to be attached to this form.

ALASKA: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under the state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties

ARKANSAS: 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 fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to be attached to this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and maybe 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.

DELAWARE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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

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

INDIANA: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or 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.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

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

NEW MEXICO: 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.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or 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 shall also be subject to a civil penalty not to exceed five thousand dollars (\$5,000.00) and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false or deceptive 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.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a 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.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a 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.

ALL OTHER STATES: Any person who knowingly and with intent to defraud an insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.