MAIL TO: *Bankers Life and Casualty Company*
Claims Department • PO Box 1936
Carmel, IN 46082-1936 • Telephone: (800) 621-3724

PATIENT'S DISABILITY REPORT

POLICY NUMBERS ____________________

NAME ____________________ **AGE** ____________

ADDRESS ____________________
(Street) (City) (State) (Zip)

IF ADDRESS IS NEW PLEASE CHECK BOX ☐

OCCUPATION ____________________ **SOCIAL SECURITY NUMBER** ____________

EMPLOYER' S NAME ____________________ **ADDRESS** ____________

YOU AND YOUR DOCTOR SHOULD COMPLETE THIS REPORT EVERY 30 DAYS OR UPON RETURN TO WORK, IF SOONER. PLEASE ANSWER ALL QUESTIONS SHOWN BELOW AND BE SURE YOUR DOCTOR ANSWERS ALL QUESTIONS ON HIS SIDE OF THE REPORT.

1. Are you still disabled? Yes ____ No ____
   If not, give date you were able to start work. Completely ___/___/___ Partially ___/___/___

2. If still disabled when do you expect to go back to work?

   FULL TIME Month____Day____ Year____ PART TIME Month____Day____Year ____

3. List those duties you couldn't do because of this condition.

4. Have you been confined indoors? If yes give dates. Yes ____ No ____
   From: ___/___/___ To: ___/___/___

5. Give dates doctor treated you since last report.
   Office ____________
   Home ____________
   Hospital ____________

6. List other loss of time insurance and Social Security
   Company ____________ Monthly Benefit ____________
   Company ____________ Monthly Benefit ____________
   State Benefits ____________ Monthly Benefit ____________
   Social Security: Family Monthly Benefits ____________
   Individual ____________

7. Remarks: ____________________

BE SURE TO SIGN BELOW

AUTHORIZATION:
I hereby authorize any medical professional, hospital, or other medical-care institution insurance support organization, governmental agency, insurance company, employer, or other organization, institution or person that has any information, records or knowledge of me or my health to furnish Bankers Life and Casualty Company or its representatives and permit them to examine and copy any information. I understand that such information will be used for the purpose of evaluating my claim for insurance benefits and that I acknowledge that I or my authorized representative have a right to a copy of this authorization upon request. A copy of this authorization, or the original shall be from the date signed for the duration of the claim or the term of the coverage.

IMPORTANT PLEASE SIGN **X**

SIGNATURE ____________________ DATE ____________
(PATIENT/GUARDIAN IF MINOR)

ADDRESS ____________________ CITY ____________ STATE ________ ZIP CODE ________

DOCTOR'S CLAIM REPORT DOCTOR PLEASE SIGN HERE AS WELL AS BELOW

AUTHORIZATION I hereby authorize Bankers Life and Casualty Company or its representatives, to inspect all X-ray pictures, clinical records and to obtain full information including etiology, diagnosis and prognosis, or other data that may be in you possession or under your control, and to make copies of same or any portion thereof, pertaining to the disability of

____________________ a patient in your care from ____________ to ____________

Date ________________ Signed X____________________________
(Attending Physician) (Degree)

To speed claim service, please answer all questions

Patient's Name____________________________ age________

Address____________________________________
(Street) (City) (State) (Zip Code)

Policy/Certificate Numbers____________________________

1. Diagnosis (Describe complications, if any.) Due to Accident: ☐ Illness: ☐
2. Give dates patient was disabled from performing usual duties. Totally From____________ To____________ Partially From____________ To____________
3. Was house confinement necessary? If yes, give dates. Yes ☐ No ☐ From____________ To____________
4. If still disabled, when should patient be able to return to work? Date____________
5. Give dates of treatment since last report. Office____________ $____________ Home ____________ $____________ Hospital ____________ $____________
6. Was patient hospitalized since date of last report? Yes ☐ No ☐ Name of Hospital____________ Confined From:____________ To____________
7. If operation was performed since date of last report please describe. Surgical Procedure____________ Date____________
8. Remarks:

Date____________ Signed X____________________________
(Please also sign authorization above) (Degree) (Social Security of Tax No.)

Address____________________________________
(Street) (City) (State) (Zip Code)

TO AVOID DELAY PLEASE ANSWER ALL QUESTIONS

FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

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

ALASKA, DELAWARE, FLORIDA, IDAHO, NEW YORK: Your state requires us to notify you that: 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 as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA: 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.

ARIZONA, KENTUCKY, OHIO: WARNING: 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.

CALIFORNIA: For your protection California law requires the following warning statement to appear on this form: 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.

COLORADO: WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

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.

INDIANA, MINNESOTA: Your state requires us to notify you that: 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.

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

NEW HAMPSHIRE: Your state requires us to notify you that any person, 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 under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

OKLAHOMA: WARNING: 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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

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