EquiTrust®
Life Insurance Company

P.O. Box 2549 ■ Waco, Texas 76702-2549
254-297-2772 ■ 1-855-297-2103
Visit us at our website: www.myetlicpolicy.com

POLICY HOLDERS CLAIM REPORT
TOTAL DISABILITY BENEFIT

POLICY NO. _____

YOUR HOME PHONE	**AREA** ( )
YOUR WORK PHONE	**AREA** ( )

PLEASE PRINT

PART I

SOCIAL SECURITY #_____

INSURED'S NAME_____ DATE OF BIRTH_____

IF CLAIM IS FOR DEPENDENT, GIVE NAME_____ RELATIONSHIP_____ DATE OF BIRTH_____

WHAT OTHER DISABILITY OR MEDICAL INSURANCE DO YOU HAVE?_____

HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY INCOME BENEFITS? ☐ Yes ☐ No

OCCUPATION

Employer's Name_____ Employer's Address_____

Your Occupation_____ Monthly Earnings $_____ Duties_____

Were you working before you became disabled? ☐ Yes ☐ No If No, what were you doing?_____

If you are self employed, is your business still operating? ☐ Yes ☐ No

NOTE: BE SURE YOUR EMPLOYER COMPLETES STATEMENT ON REVERSE

TREATMENT

When did you first receive medical treatment?_____ Where?_____

What is your Doctor's name?_____

Doctor's address_____

What other Doctors are treating you? (Name/Address)_____

If you were in the hospital, please give dates of confinement: Admitted_____ Discharged:_____

Hospital:_____ Address:_____

If you were hospitalized, please send copy of the bill.

CONDITION

Describe the sickness or injury_____

If this is a sickness, when did it first begin?_____

Have you had this condition in the past? ☐ Yes ☐ No If Yes, when?_____

If this is an accident, when and where did it happen? Date_____ Time_____ Place_____

How did it happen?_____

Describe the injuries you sustained_____

IMPORTANT: PLEASE INCLUDE A COPY OF THE POLICE REPORT IF THIS IS A VEHICLE ACCIDENT.

DISABILITY

Did the condition described above cause you to lose any time from work? ☐ Yes ☐ No

If Yes, between what dates were you unable to do any work?

First day not worked_____ Date returned to work_____

What duties were you unable to do?_____

When were you able to do SOME of your duties?_____

When were you able to do ALL of your duties?_____

INSURED SIGN HERE **X**_____ DATE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PART II ATTENDING PHYSICIAN'S REPORT

PATIENT'S NAME:			AGE:
1.	Diagnosis and concurrent conditions.		
2.	When did symptoms first appear or accident happen?		
3.	If accident, please describe.		
4.	When did patient first consult you for this condition?	DATE TIME	☐ AM ☐ PM
5.	**A** Has patient ever had same or similar conditions? If "YES" state when and describe. **B** If treated by another physician, please give name and address.	☐ Yes ☐ No	
7.	Nature of surgical procedure, if any. (Describe fully.)	Date performed_____ CHARGE:_____	
8.	If patient hospitalized, give name and address of hospital.	Hospital_____ City and State_____ Admitted_____ Discharged_____	
9.	Give dates of treatment.	Office:_____ Home:_____ Hospital:_____	
10.	Is patient still under your care for this condition? If "NO" give date your service terminated.	☐ Yes ☐ No	
11.	How long was (or will) patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	From To	
12.	How long was (or will) patient (be) partially disabled? (Able to perform some but not all of his/her occupational duties)?	From To	
13.	Describe any other disease or infirmity affecting present condition.	**Remarks**	

Date_____ Name_____MD
(PLEASE PRINT)

Address_____

Telephone (_____)_____
AREA CODE

Signed_____

INDV. PRACTITIONERS-SS NO.

ALL OTHER - EMPLOYER I.D. NO.

Must be furnished under authority of law.

PART III EMPLOYER'S STATEMENT

Employee's Name_____ Date Hired_____ Name Of Company_____

On what date did he/she first stop work entirely because of this sickness or injury?_____, 20_____

On what date did he/she resume any part of his/her work, supervisory or otherwise?_____, 20_____

Was injury or disease covered under Workmen's Compensation? ☐ Yes ☐ No Date of Injury?_____

If "Yes" give name and address of your compensation carrier _____

Date_____, 20_____ Signature of Employer_____
(TITLE)

Phone No. (_____)_____ Address_____
AREA CODE (STREET AND NO.) (CITY, STATE) (ZIP CODE)

Important Notice

In some states we are required to advise you of the following: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

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."

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.

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.

Louisiana – 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.

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

Massachusetts – 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 state prison.

New Jersey – Any person who includes any false or misleading information on an application for an insurance policy 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.

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.

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.

Puerto Rico – Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Rhode Island – 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.

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.

Virginia – Any person who, with the 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 may have violated state law.

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.

In All Other States – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing a false or deceptive statement may be guilty of insurance fraud.