



THIS FORM MUST BE RETURNED TO PROCESS YOUR CLAIM

The First Rehabilitation Life Insurance Company of America

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CLAIM # \_\_\_\_\_

DATE \_\_\_\_\_

SUPPLEMENTARY CLAIM REPORT

This report must be completed in full and returned in 2 weeks in order to process your claim

CLAIMANT'S STATEMENT (MUST BE COMPLETED)
1 - Are you still totally unable to work?
A - If not, when did you or will you return to work?
B - If yes, what prevents your return to work now?
2 - When did you or you receive Social Security benefits? AMOUNT: PER MONTH.
3 - I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to the First Rehabilitation Life Insurance Company of America, any and all information about me with reference to my health and or my medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photostatic copy of this authorization shall be as valid as the original.
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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Date Signature of Claimant Parent if a Minor

ATTENDING HEALTH CARE PRACTITIONER'S STATEMENT MUST BE COMPLETED Yes No

FOR PREGNANCY:

(a) Estimated date of delivery Month Day Year
(b) Type of Delivery (c) Complications

PRESENT CONDITION:

(a) Subjective Symptoms
(b) Objective findings Include results of current X-rays E.K.G's or any other diagnostic tests
(c) Is patient Ambulatory? Bed Confined? House Confined? Hospital Confined?

DIAGNOSIS(ES):

TREATMENT:

(a) Date of first visit Month Day Year
Date of last visit Month Day Year
Frequency of visit Weekly Monthly Other
(b) When did you last examine patient? Month Day Year

PROGRESS: Recovered Improved Unimproved Retrogressed

EXTENT OF DISABILITY:

(a) Is patient now totally disabled and unable to do any work? Yes No
(b) If "No", when was patient able to do any work? Month Day Year
(c) If "Yes", when do you think patient will be able to resume any work?
Approximate Date Month Day Year
Indefinite
Never

MENTAL CONDITION:

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes No

REMARKS:

Table with 4 columns: Date, Signature (Attending Health Care Practitioner), Degree, Telephone, Street Address, City or Town, State or Province, Zip Code

