WICHITA NATIONAL LIFE
INSURANCE COMPANY

Initial Claim
For Credit Disability Benefits

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.

Certificate Number	Certificate Date	Loan Officer/Agent

CLAIMANT'S STATEMENT (To be completed by the insured)

Full name____________________ Date of Birth ______________ Social Security #________________

Street address ____________________ City____________________ State ___________ Zip _______________

Mailing address________________________ City ______________State _____________ Zip _________ Telephone # ___________________

What is your business or occupation? ______________________________ Average monthly earnings $ ________________

Name of employer or business______________________________ Telephone # ______________________

Address______________________________ City______________________ State____________ Zip _________________

Describe your specific duties to perform you job ____

____

When did you first notice symptoms of your illness or on what date did the injury occur? __________________________

Describe disability________________________________ How did the injury happen? _________________________________

Have you ever had this or a similar condition before? ☐ Yes ☐ No If "yes" what condition and when? _______________________

What date did you first see a physician? ____________________________ Where? __________________________

Physician name ______________________________ Address_________________________ Telephone # _____________________

Has any other physician treated you for this injury or sickness? ☐ Yes ☐ No If "yes" when_______________________

Physician name ______________________________ Address_________________________ Telephone # _____________________

Is this claim the result of an accident? ☐ Yes ☐ No (If "yes" provide copy of accident report)

Are you filing claim under workman's compensation? ☐ Yes ☐ No (If "yes" provide copy of workers compensation report)

When did you become totally disabled (unable to perform usual occupation)? _____________

When did you or do you expect to return to full time work? ____________When did you or do you expect to return to light work? ____________

Have you performed any work other than your usual occupation? ☐ Yes ☐ No If "yes" give nature of work and dates worked _______________

Have you had any medical or surgical advice during the past five years for any other condition? ☐ Yes ☐ No

If "yes" what where you treated for? ______________________________ When? ________________________

Physician name ______________________________ Address_________________________ Telephone # _____________________

Who is your family physician? _________________________ Address_________________________ Telephone # _______________

Are you receiving or entitled to receive any other disability benefits? ☐ Yes ☐ No If "yes" source and amount ___________________________

Under Penalty of Perjury - I hereby certify the foregoing statement to be true and correct. I agree that any statement herein made by me and found by the Company to be false, shall render all rights under my certificate voidable at the option of the Company. I hereby direct the Company to pay all benefits accruing to me as a result of the above described disability to the first beneficiary of my above mentioned certificate.

Authorization: Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical institution, insurance support organization, pharmacy, governmental agency, insurance company, employer to provide Wichita National Life Insurance Company or agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care of treatment provided the insured named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer to provide Wichita National Life Insurance Company with financial or employment-related information.

I understand that such information will be used by the Company for the purpose of evaluating my claim for insurance benefits and that I or my authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the term of the certificate.

____ ______________________________

Signature of Insured Date

ALL QUESTIONS MUST BE FULLY ANSWERED OR DELAY IN PROCESSING CLAIM WILL OCCUR

PHYSICIAN'S STATEMENT (To be completed by the treating physician)

Patient's name ____________________

Diagnosis of disability ____________________

Date symptoms appeared or injury happened ____________________

Date patient first consulted you for this condition ____________________ Date diagnosis given to patient ____________________

Nature of surgical or obstetrical procedure, if any____________________

If hospitalized ____________________ Date admitted __________ Discharged ________
(Name of Hospital) (City) (State)

Is condition due to pregnancy? ☐ Yes ☐ No If "yes" date pregnancy commenced ____________________

Dates of office visits/treatment within the last 60 days for this disability ____________________

Has patient ever had same or similar condition? ☐ Yes ☐ No If "yes" when ____________________

Is patient still under your care for this condition? ☐ Yes ☐ No If "no" date of discharge ____________________

For what have you previously treated patient? (state condition and dates) ____________________

How long have you been his/her physician? ____________________

Was patient referred to you? ☐ Yes ☐ No If "yes" please identify ____________________
(Name) (Address) (City) (State) (Telephone #)

Is patient totally disabled from usual occupation? ☐ Yes ☐ No Is patient disabled from any occupation? ☐ Yes ☐ No

Dates of total disability: From ______________To______________ Dates of partial disability: From ______________To______________

If patient is still disabled what is estimated return to work date? ____________________

Restrictions placed on patient's work ____________________

Treatments prescribed ____________________

Printed name____________________Signature____________________ Date Signed____________
(Attending Physician) (Attending Physician)

____
(Street Address) (City or Town) (State) (Zip Code) (Telephone #)

EMPLOYER'S STATEMENT (To be completed by employer)

Name of company ____________________Employee name____________________

Date of hire ____________________ Description of duties ____________________

Do you classify this as light, medium or heavy work? ____________________ Average hours worked per week ____________________

Do you have light duty available? _________ Will job be held open for employee? _________ First full date absent (due to disability) __________

First date returned ___________ Did employee work any period between these dates? ☐ Yes ☐ No If "yes" list dates ____________________

Has employee filed claim for this loss under workers compensation insurance? ________ If "yes", list name, address and telephone number of carrier____________________

Signature of employer____________________ Title ____________________ Date____________________

____
(Address of Employer) (City or Town) (State) (Zip Code) (Telephone #)

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Please return form to: Wichita National Life Insurance Company ~ PO Box 1709 ~ Lawton, OK 73502 ~ (580) 353-5776