WICHITA NATIONAL LIFE INSURANCE COMPANY

INSURED'S STATEMENT/AFFIDAVIT

PLEASE DO NOT COMPLETE BEFORE _____ OR YOU MAY BE REQUIRED TO COMPLETE ANOTHER FORM BEFORE ANY BENEFITS ARE PAID.

Claimant's Name: _____

I hereby authorize any physician, medical practitioner, hospital, clinic, credit bureau, the Medical Information Bureau or any medical or medically related facility, insurance company, employer or other organization, institution or person, or governmental facility, that has any records or knowledge of me to give to Wichita National Life Insurance Company any and all information requested.

Notice: Information authorized for release may include information on drug or alcohol use, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunize Deficiency Virus/Acquired Immune Deficiency Syndrome), psychotic or other mental conditions, or any other conditions for which you may have been treated while a patient.

UNDER PENALTY OF PERJURY IF UNTRUE, I hereby certify that I have not applied for, nor am I receiving any unemployment benefits. I have not been actively working at my regular occupation, nor have I been able to perform any other occupation for wages or profit, as a result of my injury/illness.

I was totally disabled from _____ to _____.

I returned to work on (include part-time with number of hours worked per day) _____.

Note: The date you were totally disabled **must be completed** on this form or it will be returned to you for completion.

If you remain totally disabled at the time of completing this form, please show the date you are "totally disabled to" as the current date. If you are not totally disabled and have returned to work, show the date you returned to work.

_____ _____

Signature of Claimant Date

Subscribed and sworn before me on this _____ day of the month of _____ 2_____.

_____ My commission expires _____

Notary Public

(Seal)

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".

Revised (7-2007)

P.O. BOX 1709 ● LAWTON, ● OK. ● 73502 ● Phone (580) 353-5776 ● Fax (580) 353-6482