WICHITA NATIONAL LIFE INSURANCE COMPANY

A&H Claim Progress Report

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

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.

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

Full name _____ Describe disability _____

List Physicians who have treated you in the last 30 days _____

Have you been to your employment during the past 60 days? ☐ Yes ☐ No If "yes" list dates and reason _____

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

_____

If you have not already done so, when do you expect to resume any part of your duties? _____

Are you receiving or have you applied for disability/unemployment benefits? ☐ Yes ☐ No If "yes" list source_____

Signature_____Date _____

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

Diagnosis of disability _____Has patient's condition improved since last report? ☐ Yes ☐ No

Have any complications arisen since last report? ☐ Yes ☐ No If "yes" please describe_____

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_____

Dates of hospital confinement: From_____ To _____

Restrictions placed on patient's work _____

Treatments prescribed _____

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

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_____

First 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 #)

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

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

CAH-PR2009