

**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
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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 #)

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