

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 369 ~ West Chester, OH 45071~ (800) 522-1625