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