

- American-Amicable Life Insurance Company of Texas
- IA American Life Insurance Company
- Industrial Alliance Insurance and Financial Services Inc.
- Occidental Life Insurance Company of North Carolina
- Pioneer American Insurance Company
- Pioneer Security Life Insurance Company

P.O. Box 2549 • Waco, TX 76702-2549 • 800-736-7311

**POLICY HOLDERS CLAIM REPORT  
TOTAL DISABILITY BENEFIT**

POLICY NO. \_\_\_\_\_

<b>YOUR HOME PHONE</b>	<b>AREA ( )</b>
<b>YOUR WORK PHONE</b>	<b>AREA ( )</b>

PLEASE PRINT

**PART I** SOCIAL SECURITY # \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

IF CLAIM IS FOR DEPENDENT, GIVE NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

WHAT OTHER DISABILITY OR MEDICAL INSURANCE DO YOU HAVE? \_\_\_\_\_

HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY INCOME BENEFITS?  Yes  No

<b>OCCUPATION</b>	Employer's Name _____ Employer's Address _____
	Your Occupation _____ Monthly Earnings \$ _____ Duties _____
	Were you working before you became disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what were you doing? _____
	If you are self employed, is your business still operating? <input type="checkbox"/> Yes <input type="checkbox"/> No NOTE: BE SURE YOUR EMPLOYER COMPLETES STATEMENT ON REVERSE
<b>TREATMENT</b>	When did you first receive medical treatment? _____ Where? _____
	What is your Doctor's name? _____ Doctor's address _____
	What other Doctors are treating you? (Name/Address) _____
	If you were in the hospital, please give dates of confinement: Admitted _____ Discharged: _____ Hospital: _____ Address: _____
	<i>If you were hospitalized, please send copy of the bill.</i>
<b>CONDITION</b>	Describe the sickness or injury _____
	If this is a sickness, when did it first begin? _____
	Have you had this condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____
	If this is an accident, when and where did it happen? Date _____ Time _____ Place _____
	How did it happen? _____ Describe the injuries you sustained _____ IMPORTANT: PLEASE INCLUDE A COPY OF THE POLICE REPORT IF THIS IS A VEHICLE ACCIDENT.
<b>DISABILITY</b>	Did the condition described above cause you to lose any time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, between what dates were you unable to do any work? First day not worked _____ Date returned to work _____
	What duties were you unable to do? _____
	When were you able to do SOME of your duties? _____
	When were you able to do ALL of your duties? _____

INSURED SIGN HERE **X** \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**PART II**

**ATTENDING PHYSICIAN'S REPORT**

PATIENT'S NAME:		AGE:	
1.	Diagnosis and concurrent conditions.		
2.	When did symptoms first appear or accident happen?		
3.	If accident, please describe.		
4.	When did patient first consult you for this condition?	DATE	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
5.	<b>A</b> Has patient ever had same or similar conditions? If "YES" state when and describe.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>B</b> If treated by another physician, please give name and address.		
7.	Nature of surgical procedure, if any. (Describe fully.)	Date performed _____ CHARGE: _____	
8.	If patient hospitalized, give name and address of hospital.	Hospital _____ City and State _____ Admitted _____ Discharged _____	
9.	Give dates of treatment.	Office: _____ Home: _____ Hospital: _____	
10.	Is patient still under your care for this condition? If "NO" give date your service terminated.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	How long was (or will) patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	From	To
12.	How long was (or will) patient (be) partially disabled? (Able to perform some but not all of his/her occupational duties)?	From	To
13.	Describe any other disease or infirmity affecting present condition.	<b>Remarks</b>	

Date \_\_\_\_\_ Name \_\_\_\_\_ MD  
(PLEASE PRINT)

Address \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_  
AREA CODE

Signed \_\_\_\_\_

INDV. PRACTITIONERS-SS NO.  
[ ]

ALL OTHER - EMPLOYER I.D. NO.  
[ ]

Must be furnished under authority of law.

**PART III EMPLOYER'S STATEMENT**

Employee's Name \_\_\_\_\_ Date Hired \_\_\_\_\_ Name Of Company \_\_\_\_\_

On what date did he/she first stop work entirely because of this sickness or injury? \_\_\_\_\_, 20\_\_\_\_

On what date did he/she resume any part of his/her work, supervisory or otherwise? \_\_\_\_\_, 20\_\_\_\_

Was injury or disease covered under Workmen's Compensation?  Yes  No Date of Injury? \_\_\_\_\_

If "Yes" give name and address of your compensation carrier \_\_\_\_\_

Date \_\_\_\_\_, 20\_\_\_\_ Signature of Employer \_\_\_\_\_ (TITLE)

Phone No. (\_\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_ (STREET AND NO.) (CITY, STATE) (ZIP CODE)

## Important Notice

In some states we are required to advise you of the following: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

**Arizona** – “For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.”

**Colorado** – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia** – Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida** – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Louisiana** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maryland** – “Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

**Massachusetts** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in state prison.

**New Jersey** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New Mexico** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Oklahoma** – **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.

**Pennsylvania** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico** – Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**Rhode Island** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee** – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Virginia** – Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Washington** – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**In All Other States** – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application containing a false or deceptive statement may be guilty of insurance fraud.