

INVESTORS HERITAGE Life Insurance Company

200 Capital Avenue • P.O. Box 717

FRANKFORT, KENTUCKY 40602

(800) 422-2011

Fax: (502) 223-6575

CLAIM NUMBER: _____**APPLICATION FOR CONTINUANCE OF DISABILITY BENEFITS**

Claimant's Name: _____

Current Address: _____
NUMBER AND STREET CITY STATE ZIP-CODE Check here if this is a new address

Phone Number: () _____ E-Mail: _____

For your convenience, we are providing you with this form for submitting your claim under the total disability clause of your policy. Please complete the statement below and have your doctor complete an Attending Physician's Statement. **YOU MUST RETURN THESE FORMS TOGETHER.** Upon receipt of this information you may be assured that your claim will be given our prompt attention.

STATEMENT OF CLAIMANT

LOAN NUMBER: _____	Providing your Loan Number will assist the Financial Institution in applying any payments issued.
(1) Are you at present doing or supervising any work?	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please give nature of work and time spent. _____ _____
(2) Are you able to perform the duties of your current occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(3) Are you able to perform any work for compensation or profit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) If not working, when do you think you will be able to return to work?	Date: _____ Month Day Year
(5) Are you receiving or have you received disability pension or compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(6) Have you applied for Social Security Benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please give dates: _____
(7) Are you receiving Social Security Benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please give date of entitlement _____
(8) Are you receiving or have you received workers compensation?	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please give dates: _____
(9) What are you present earnings?	\$ _____ per month Source: _____

(QUESTIONS CONTINUED ON BACK)

<p>(10) Have you been to a hospital or sanitarium since you last reported to the Company?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes - Please give dates, name and address of facility _____ _____</p>
<p>(12) What doctors have you seen since last reporting to the Company?</p>	<p>Name of Doctor: _____ Address: _____ _____</p>
<p>(13) Are you confined to bed or home?</p>	<p>Bed: <input type="checkbox"/> Yes <input type="checkbox"/> No Home: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

AUTHORIZATION FOR RELEASE OF MEDICAL AND EMPLOYMENT INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Veteran's Administration, the Medical Information Bureau, Inc., my employer, consumer reporting agency or insurance or reinsurance company who possess information on the care, treatment or advice of me to furnish such information to INVESTORS HERITAGE LIFE INSURANCE COMPANY, hereinafter called the company, or its legal representative upon presenting this Authorization or a photocopy. The Company, its reinsurers, insurance support organizations and their authorized representatives, may obtain medical and other information, in order to determine eligibility for benefits under an existing policy. This Authorization shall include information concerning drugs, alcoholism or mental illness. I understand that the Company or its reinsurers may make a brief report concerning me to other insurance companies to determine eligibility for benefits under an existing policy. I authorized the Company to obtain an investigative consumer report on me if necessary to determine eligibility for benefits under an existing policy. I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for the duration of my claim from the date shown below. The above answers are true and correct to the best of my knowledge and belief. I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a false or deceptive statement is guilty of insurance fraud.

YOU ARE RESPONSIBLE FOR LOAN PAYMENTS AND ANY LATE CHARGES WHILE YOUR CLAIM IS BEING PROCESSED. IF ALL QUESTIONS ON THIS FORM ARE NOT COMPLETED IN FULL IT MAY CAUSE A DELAY IN YOUR CLAIM.

Date: _____ **Signature of Insured:** _____

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(800) 422-2011

Fax: (502) 223-6575

Benefit Payments Direct Watts: (877) 694-8706

ATTENDING PHYSICIAN'S STATEMENT

(PLEASE FORWARD ALL RECENT TEST RESULTS AND OFFICE NOTES)

THE PATIENT IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO INVESTORS HERITAGE LIFE INSURANCE COMPANY. THESE QUESTIONS MUST BE ANSWERED BY YOUR PHYSICIAN.

(PLEASE PRINT)

Name of Patient: _____	Claim No.: _____
Patient's Address: _____	Date of Birth: _____
_____	Month Day Year

HISTORY:

(a) When did symptoms first appear or accident happen? Month _____ Day _____ Year _____

(b) Last date patient was able to work: Month _____ Day _____ Year _____

(c) Has patient every been treated for the same of similar conditions? YES NO

If yes, please describe any pertinent past history: _____

If the patient has been referred to you for consultation or treatment, please list referring physician(s) below.

If you referred the patient to another physician for consultation or treatment, please list the name and address of the physicians(s):

DIAGNOSIS: ICD Code(s)

(a) Date first seen: Month Day Year Date Last seen: Month Day Year

(b) PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____

List any complications: _____

(c) Describe OBJECTIVE FINDINGS, X-Ray Interpretations, EKG Interpretations, LAB studies, ROM and other Clinical Findings - If pregnancy, please give due date. _____

PLEASE FORWARD ALL PERTINENT RECORDS REGARDING THIS INCIDENT/OR COMPLAINT

CONDITION:

- a. Has patient Recovered Improved Unchanged Retrogressed
b. Is patient Ambulatory House Confined Bed Confined Hospitalized

If hospitalized, please name state dates(s): From _____ Through _____
Institution's name and address: _____

SPECIAL LIMITATIONS: (if applicable)

CARDIAC function per A.H.A.: (if applicable)

- Class 1: No limitation for normal work activity (unlimited)
- Class 2: Limited to lifting 30 to 50 lbs. (heavy work)
- Class 3: Limited to lifting 20 to 30 lbs. (medium work)
- Class 4: Limited to lifting 10 to 20 lbs. (light work)
- Class 5: Severely limited: able to perform sedentary or less

MENTAL STATUS:

In your interview did you note any evidence of Mental or Emotional instability? YES NO
 Psychological Psychotic

PROGNOSIS:

- a. In your reasoned medical judgment do you consider the patient able to return to his/her former work?
 YES NO
- b. If the patient cannot return to his/her former work is he/she capable of performing any work for compensation?
 YES NO
- c. If patient is unable to work at any level, when do you expect patient to improve so he/she may return to work?
(Please do not use the terms "indefinite", "unknown", "undetermined", etc. If a definite date cannot be determined, please approximate in days, weeks, or months, how long total disability will continue from the date of the most recent treatment as indicated above.)

ONSET: Month _____ Day _____ Year _____
RETURN TO WORK: Month _____ Day _____ Year _____

WORK HARDENING/REHABILITATION:

Is the patient a candidate for either a work hardening or vocational rehabilitation program? YES NO
Is the patient enrolled in a rehabilitation program? YES NO
If YES, please give name and address of program: _____

Name (attending physician) PLEASE PRINT	Degree/Specialty	Telephone Number
Street Address	City or Town	State or Providence
		Zip Code
Signature	Date	Taxpayer Identification Number