

**INVESTORS HERITAGE** Life Insurance Company

200 Capital Avenue • P.O. Box 717  
FRANKFORT, KENTUCKY 40602  
(800) 422-2011  
Fax: (502) 223-6575

**STATEMENT OF INSURED PATIENT**

**BEFORE PROCESSING OF YOUR CLAIM CAN BEGIN, YOU MUST RETURN:  
THE STATEMENT OF INSURED PATIENT ALONG WITH THE ATTENDING PHYSICIAN'S STATEMENT AND A COPY  
OF YOUR CREDIT A&H POLICY TO THE ABOVE ADDRESS.**

<b>PART A - PLEASE ANSWER ALL QUESTIONS</b>			
Your Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address:		Town:	State: Zip:
Have you filed a claim with Investors Heritage before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security No.:	
Your occupation:		Home Phone No. ( )	
Describe your duties		Average monthly earnings \$	
		Supervisor:	
Name and address of your Employer:			
Telephone No. ( )		When did you cease work? Month _____ Day _____ Year _____ Time: _____	
When did you or do you expect to return to work?			
Phone No. where you can be reached during the day ( )			
1. Is your disability caused by: <input type="checkbox"/> Injury? <input type="checkbox"/> Sickness? Please explain in detail, Nature of Sickness or Injury, give date, place and circumstances.			
2. If Sickness, when did symptoms appear? Month _____ Day _____ Year _____			
3. If you were hospitalized, give name and address of Hospital and date of confinement.			
4. Have you ever had this or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date:			
5. What doctors have treated you for any sickness or accident in the last 5 years?			
<b>(A) Names and complete address of doctor</b>		<b>(B) Why were you treated?</b>	<b>(C) Date you were treated</b>
6. Are you receiving or have you received disability pension or compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of first payment Month _____ Day _____ Year _____ From whom:			
7. Have you applied for Social Security Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:			
8. Are you receiving or have you received workers' compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No From whom:			

**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 reinsuring company who possess information on the care, treatment or advise provided to me, to furnish such information to INVESTORS HERITAGE LIFE INSURANCE COMPANY, hereinafter called the company or its legal representatives 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. The Authorization shall include information concerning drugs, alcoholism or mental illness. I understand that the Company or its reinsured may make a brief report concerning me to other insurance companies to determine eligibility for benefits under an existing policy. I authorize 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 or any claim from the date show below. I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an Insurer, files a claim containing a false or deceptive statement is guilty of Insurance fraud. The above statements are true and correct to the best of my knowledge and belief.

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

Date \_\_\_\_\_ Signature : \_\_\_\_\_

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## PART B

### **STATEMENT OF FINANCIAL INSTITUTION THIS SECTION TO BE COMPLETED BY THE LENDING INSTITUTION ATTACH COPY OF POLICY FACE WITH FIRST CLAIM**

Name of Insured \_\_\_\_\_

Amount of Policy \_\_\_\_\_ Policy No. \_\_\_\_\_ Date if Loan \_\_\_\_\_ Term \_\_\_\_\_

Insured's Loan Number(s) **(Required)** \_\_\_\_\_

Name of Authorized Representative (please print) \_\_\_\_\_

Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Financial Institution \_\_\_\_\_

\_\_\_\_\_ Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dealership Name (if any) \_\_\_\_\_

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## PART C

### **EMPLOYER'S STATEMENT**

Employee's Name \_\_\_\_\_

Was he/she a full or part-time employee at beginning of this disability?  Full-time  Part-time

Was he/she laid off prior to beginning of disability?  Yes  No If so, on what date \_\_\_\_\_

Date Employee last worked \_\_\_\_\_

Date Employee resumed any part of his work, supervisory or otherwise \_\_\_\_\_

Was injury or disease covered under workmen's compensation?  Yes  No

Name & Address of your compensation carrier \_\_\_\_\_

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_ E-mail: \_\_\_\_\_

Name of Authorized Representative (please print) \_\_\_\_\_

Signature of Authorized Signer \_\_\_\_\_ Date: \_\_\_\_\_

Title \_\_\_\_\_

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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
Signature	Date	Zip Code
		Taxpayer Identification Number