

Date of illness or injury: _____

If Illness, have you been treated before? _____

If Injury, describe: _____

Name and Address of Attending Physician:

Section 4 – Physicians Statement

Diagnosis or nature of illness or injury

Date of illness (first symptom) or injury _____ Date first consulted for this condition

Hospital confinement dates: From _____ To _____ Date able to return to work

Total disability dates: From _____ To _____ Partial disability dates: From _____ To

Place of service _____ Diagnosis code and description

Physician's Signature _____ Date _____

Address and Telephone Number:

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I agree that a photographic copy of this Authorization shall be a valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative

Dated

Address:

Fraud 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.”
