

THE UNITED STATES LIFE Insurance Company
A US LIFE COMPANY

NOTICE OF CLAIM FOR SHORT TERM DISABILITY BENEFITS

POLICY NUMBER:

CERTIFICATE NUMBER:

CLASS:

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

EMPLOYEE'S STATEMENT . . . (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

NAME OF EMPLOYEE		MALE <input type="checkbox"/>	EMPLOYEE'S SOCIAL SECURITY OR	
		FEMALE <input type="checkbox"/>	I.R.S. NUMBER	
EMPLOYEE'S ADDRESS	STREET & NO.	CITY	STATE	ZIP
			TELEPHONE NO.	DATE OF BIRTH MO. DAY YR.
DATE ACCIDENT OR SICKNESS BEGAN		DATE LAST WORKED		DATE FIRST TREATED
NATURE OF SICKNESS OR INJURY			IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?	
			DID ACCIDENT HAPPEN AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PHYSICIAN'S NAME AND ADDRESS FIRST CONSULTED FOR THIS CONDITION			LIST NAME AND ADDRESS OF YOUR FAMILY PHYSICIAN	
NAME AND ADDRESS OF HOSPITAL, IF CONFINED			DATES OF CONFINEMENT IN _____ OUT _____	
Are you entitled to Benefits from any of the following for this disability?				
<input type="checkbox"/> Workman's Compensation	<input type="checkbox"/> Salary Continuance	<input type="checkbox"/> Local, State or National Association or Society Disability Income Plan		
<input type="checkbox"/> Social Security	<input type="checkbox"/> Any Government Agency	<input type="checkbox"/> None		
IF "YES" INSERT POLICY NUMBER, NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS OR SERVICES.				
POLICY NO.		NAME AND ADDRESS		
POLICY NO.		NAME AND ADDRESS		
To all physicians and other medical professionals, hospitals and other medical-care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators: You are authorized to provide The United States Life Insurance Company (USL) and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on USL's behalf, with information concerning medical care, advice, treatment or supplies provided the Patient, including information relating to mental illness and drug abuse or alcoholism, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administrating claims for benefits. I understand that this authorization is valid for the duration of my claim for benefits under USL's policy. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.				
SIGNATURE OF EMPLOYEE			DATE	

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT . . . (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

NAME OF EMPLOYEE		OCCUPATION	IS DISABILITY DUE TO EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	NUMBER OF HOURS WORKED PER WEEK	SALARY \$ <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month
DATE EMPLOYED MONTH DAY YEAR	DATE INSURED MONTH DAY YEAR	DATE LAST WORKED MONTH DAY YEAR	REASON FOR STOPPING WORK <input type="checkbox"/> Dismissed <input type="checkbox"/> Lv of Absence <input type="checkbox"/> Disability <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> Layoff		
DATE RETURNED TO WORK <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME MO. DAY YR. MO. DAY YR.		IF PART-TIME, HOURS PER <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <small>*Please attach supporting documents to show part-time earnings</small>	IF EMPLOYEE HAS NOT RETURNED TO WORK, APPROXIMATE RETURN TO WORK DATE MONTH DAY YEAR	DATE EMPLOYMENT TERMINATED MONTH DAY YEAR	DATE INSURANCE TERMINATED MONTH DAY YEAR
PREMIUM CONTRIBUTION PERCENTAGE EMPLOYER _____% EMPLOYEE _____%		IF EMPLOYEE CONTRIBUTES TOWARDS THE COST OF DISABILITY COVERAGE, PLEASE INDICATE IF BEFORE <input type="checkbox"/> OR AFTER <input type="checkbox"/> INCOME IS TAXED.			

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

NAME OF POLICYHOLDER (COMPANY)	PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE
MAILING ADDRESS OF POLICYHOLDER (COMPANY)	SIGNATURE
TELEPHONE NUMBER	DATE

DOCTOR'S STATEMENT

(Please Print or Type)

THE DOCTOR'S STATEMENT MUST BE FILLED IN COMPLETELY BY A PHYSICIAN.

Claimant's Name FIRST MIDDLE LAST Age Male Female

1. HISTORY

- (a) Has patient ever had same or similar condition?
(b) Is condition due to injury or sickness arising out of patient's employment?
(c) Names and addresses of other treating physicians

2. DIAGNOSIS

- (a) Diagnosis (including any complications)
(b) Subjective symptoms
(c) Objective findings (Including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. For pregnancy disability only:

- Are there any present complications or anticipated difficulties in connection with:
(a) Pregnancy
(b) Delivery
(c) Post Partum
If yes to any of the above, please specify in detail:

4. Enter dates for the following:

- (a) Date symptoms first appeared or accident happened
(b) Date patient was unable to work because of disability
(c) Date of your first treatment for this disability
(d) Date of your most recent treatment for this disability
(e) Frequency of treatment
(f) Date claimant will be able to perform usual work
(g) For pregnancy disability only, expected date of delivery

Table with 3 columns: MONTH, DAY, YEAR

5. NATURE OF TREATMENT (including Surgery and medications prescribed, if any)

6. PROGRESS

- (a) Has patient Recovered? Improved? Unchanged? Retrogressed?
(b) Is patient Ambulatory? House confined? Bed confined? Hospital confined?
(c) Has patient been hospital confined? Confined from through

7.

ATTENDING PHYSICIAN'S SIGNATURE DATE
PHYSICIAN'S NAME (PLEASE PRINT) DEGREE TEL.NO.
OFFICE ADDRESS NUMBER STREET CITY OR TOWN STATE ZIP CODE