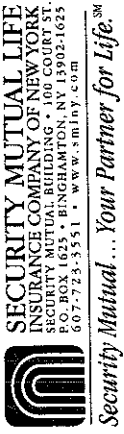


DISABILITY
LIFE INSURANCE
CLAIM FORM



INSURED'S STATEMENT

IMPORTANT: *This form is to be completed by you and your attending physician and returned to the Home Office as soon as possible.*

Name		Date of birth	Policy number
Social Security Number		Residence address	
Employer		Business address	
Date of sickness or accident		Date stopped work	Occupation
Nature of sickness or injuries		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
If injury, how and where did accident happen?			
Have you had the same or similar sickness or injury before? Give dates and details			
Name of physicians	Address		Date of first treatment
Name of hospital	Address		Admitted
Date you first resumed any duties		Discharged	
If still disabled, describe present activities		If not resumed, when do you expect to?	
What other disability insurance do you have? Names of companies		Amount	

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person who has attended me or has any records or knowledge of me or my health to furnish to Security Mutual Life Insurance Company of New York, or its representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

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.

Date

Signed

DISABILITY
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CLAIM FORM



SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607-723-3351 • www.smlife.com

Security Mutual ... Your Partner for Life.™

ATTENDING PHYSICIAN'S STATEMENT

Patient's name		Age
Nature of sickness or injury (Describe complications, if any)		
When did symptoms first appear or accident happen?	Date	
When did patient first consult you for this condition?	Date	
Has patient ever had same or similar condition? (If "Yes" state when and describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature of surgical procedure, if any. (Describe fully)		
Give dates of treatment.	Office	
	Home	
	Hospital	
If patient hospitalized, give name and address of hospital.	Admitted	Discharged
	From	Through
Remarks		
Date	Signed	
Street address	City or town	State
	Zip Code	



DISABILITY
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CLAIM FORM



SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
20 • BOSTON, MASSACHUSETTS 02108
617-722-3351 • WWW.SMLIFECOM

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EMPLOYER'S STATEMENT

Employee's name	Date employed	Occupation	Policy number
Social Security Number	Date of birth		
Base annual compensation (exclusive of bonuses, overtime, etc.)	Date last worked		
Reason for leaving <input type="checkbox"/> Disability <input type="checkbox"/> Lay Off <input type="checkbox"/> Dismissed <input type="checkbox"/> Quit <input type="checkbox"/> Leave <input type="checkbox"/> Retired			
Date returned to work	If not, expected date		
Is employee entitled to Workers' Compensation for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Effective date of employee's or dependent's insurance	Amount of insurance	Classification	Date of termination of insurance
Date	Signed		Title
Name of firm	Business address		

PLAN ADMINISTRATOR'S STATEMENT

Effective date of employee's or dependent's insurance	Classification	Date of termination of insurance
Date	Signed	Title