

GULF GUARANTY LIFE INSURANCE COMPANY

P. O. Box 12409 • Jackson, Mississippi 39236-2409

CERTIFICATE OF ATTENDING PHYSICIAN

**BE SURE ALL QUESTIONS HAVE BEEN ANSWERED
To Be Furnished Without Expense to the Insurance Co.**

1. Patient's Full Name _____
2. Address _____
(Street) (Mailing if Different) (City) (State) (Zip Code)
3. Describe total Disability: _____
4. When Did You First Treat Patient For The Existing Condition? _____
5. Has the Claimant previously suffered from the same or similar illness? _____
If yes, give Date and Diagnosis
6. Is total disability the result of a work injury or accident? If yes, give date 8: place of injury or accident. _____

7. Prognosis _____
8. List dates of all consultations and or visits for said accident or illness. _____

9. Nature of operation, if any _____
10. Names and Addresses of Physicians who previously treated patient for the above condition _____
11. If Hospitalized, give dates: From _____ 20 ____ To _____ 20 ____
Name of Hospital _____ Address _____
12. Give dates Insured was TOTALLY DISABLED from performing ANY and EVERY kind of duty pertaining to ANY occupation:
_____ From _____ 20 ____ To _____ 20 ____
13. On what date did you release patient to perform ANY duties? _____ 20 ____
14. If not released, estimated length of disability _____ (Weeks or Months)
Date _____ 20 ____ Signed _____ M.D.
Address _____

Phone () _____

TO BE COMPLETED BY THE FINANCIAL INSTITUTION OR AGENT:

15.	Certificate/Reference	Date of Issue	Term in Months	Policy Expires _____
	No. _____	_____	_____	

First Beneficiary - Creditor _____
Date _____ 20 ____ Address _____

By _____
Phone () _____

GULF GUARANTY LIFE INSURANCE COMPANY
 P. O. Box 12409 • Jackson, Mississippi 39236-2409
STATEMENT OF ACCIDENT OR SICKNESS CLAIM

STATEMENT OF THE INSURED:

This is to certify that I am the insured under the Policy numbered below. That I have been totally disabled, and for the purpose of applying for benefits under the Policy, furnish the following information which I warrant to be true, complete and correct.

16. Full Name of Insured _____
 Address _____
(Street) (Mailing if Different) (City) (State) (Zip Code)
 Date of Birth _____ Policy Issued By _____ Certificate No. _____
 Present Occupation _____ Social Security No. _____
 Name and Address of Employer _____
20. Name and Address of Employer _____
21. Describe the Disability for which this claim is made _____
22. How long have you had condition(s) causing disability? _____
23. Full Name of all Physicians who attended you for this illness _____
24. Name Doctors who have attended you in past Five years _____
25. When did you work last? Date _____ Time _____
26. From and to what dates were _____
 Have you returned to work? _____
27. _____
 If yes, give date _____
28. I hereby assign to _____ to the extent of its interest as creditor any indemnity payable under this claim.
- I hereby agree the furnishing of this form, or its acceptance by the Company as a proof, is not to be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.
- 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, that has any record or knowledge of me or my health, to give to the Gulf Guaranty Life Insurance Co., or its Reinsurer, any such information. (Photostatic copy may be used.)
 This health information is used/disclosed/obtained for the following purpose: PAYMENT OF DISABILITY CLAIM. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. By providing this authorization, I understand:
 1. I may refuse to sign this authorization and it is strictly voluntary.
 2. The health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal privacy rules.
 3. I may revoke this authorization at any time by notifying my health care provider in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
 4. This authorization will expire 180 days from the date signed.
 5. I have the right to receive a copy of this form after I sign it.
29. Date _____ Signed _____
(Insured)

EMPLOYER'S CERTIFICATE
 (Must be Fully Completed)

- I am the employer of the above named insured, and for the purpose of furnishing information to the above Insurance Company to induce payment of claim of said employee, do certify as follows:
30. Date of Employment _____ Duties _____
 31. Said employee was absent from job due to illness or accident as follows, from _____
(Beginning Date) to _____
 32. If work-related disability, give date of accident _____ 20 _____
 33. During absence of employee from job on above period, employee performed no duties for employer except as follows:
 Exceptions: _____

Date _____
 My Official Position is _____
 Signed _____
(Name of Employer)
 Address _____
 Phone () _____