

# 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 \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_
17. Address \_\_\_\_\_  
(Street) (Mailing if Different) (City) (State) (Zip Code)
18. Date of Birth \_\_\_\_\_ Policy Issued By \_\_\_\_\_ Certificate No. \_\_\_\_\_
19. Present Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_
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 \_\_\_\_\_  
for what illness or injury \_\_\_\_\_
25. When did you work last? Date \_\_\_\_\_ 20 \_\_\_\_\_ Time \_\_\_\_\_
26. From and to what dates were \_\_\_\_\_ 27. Have you returned to work? \_\_\_\_\_  
you continuously disabled? From \_\_\_\_\_ To \_\_\_\_\_ 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 (AIDS). 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 \_\_\_\_\_ 20 \_\_\_\_\_ 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 \_\_\_\_\_ to \_\_\_\_\_  
(Beginning Date)
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 \_\_\_\_\_  
(Name of Employer)

My Official Position is \_\_\_\_\_ Signed \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

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## 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 ( ) \_\_\_\_\_

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### TO BE COMPLETED BY THE FINANCIAL INSTITUTION OR AGENT:

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

First Beneficiary - Creditor \_\_\_\_\_  
Date \_\_\_\_\_ 20 \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
By \_\_\_\_\_  
Phone ( ) \_\_\_\_\_