GULF GUARANTY LIFE INSURANCE COMPANY

7 River Bend Place Flowood, Mississippi 39232 601-981-4920

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 (___) _____

Form A & H 200 / 2007

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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 (___) _____

TO BE COMPLETED BY THE FINANCIAL INSTITUTION OR AGENT:

15.

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

First Beneficiary - Creditor _____

Date _____ 20 _____ Address _____

_____

By _____

Phone (___) _____

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