WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON, PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

POLICYHOLDER'S REPORT

Please Print *POLICYHOLDER COMPLETE THIS SIDE*

Failure to complete all questions will delay claim

POLICY NUMBER(S)

1. Write only the policy numbers on which you are making this claim
2. Fill in your name (Insured) _____ Age _____
3. a. Insured's address_____ City _____ State _____ Zip_____

   b. Insured's Social Security No. _____ - _____ - _____
4. Fill in your telephone number and area code. Area Code ( ) Telephone Number _____-_____
5. What were you treated for? (Please check) _____☐ Sickness or _____☐ Accident
6. Describe the sickness or accident in your own words. _____

   _____
7. When did symptoms first appear or accident happen? _____ _____ _____
   Month Day Year
8. What date did a doctor first treat you for this sickness or accident? _____ _____ _____
   Month Day Year
9. a. Did you ever have these symptoms before? (Check one) _____☐ Yes _____☐ No
   If the answer is yes, when were they noticed or treated in the last 2 years?

   b. Please list the dates here. _____

   c. Previous Hospital Confinements. _____
10. Did you stay in the hospital for this sickness or accident? (Check one) _____☐ Yes _____☐ No

    If yes, what is the name and address of the hospital? (Attach itemized bill) _____

    _____
11. On what date were you first able to do any part of your work? _____
12. Give first date you did not work because of this sickness or injury. _____
13. Are you now totally unable to engage in any work, occupation or business? _____☐ Yes _____☐ No
14. What is your occupation? _____
15. Name and address of employer. _____
16. Employer's telephone number. Area Code ( ) Telephone Number _____-_____
17. Name of other companies with whom you have accident, health or hospital insurance. _____

    _____
18. Who is the family doctor and what other doctors have you seen in the last two years?

Family Doctor (Name and Address)	For how long	Other Doctors (Name and Address)	For How Long

AUTHORIZATION FOR PATIENT'S RECORD

I, the undersigned, do hereby authorize any hospital, physician, insurance company, employer or association to furnish to North Carolina Mutual Life Insurance Company, their representatives, Equifax, Inc., or any other representative, any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records (or photostats thereof if requested). A photostatic copy of this Authorization shall be considered as effective and valid as the original. Authorization valid for 12 months.

Insured must sign here X_____ Date_____

(IF MINOR – PARENT MUST SIGN)

DOCTOR MUST COMPLETE THE OTHER SIDE

Attending Physician's Statement – Accident or Sickness
Disability/Hospital Claim Form

This side must be completed by the attending physician

North Carolina Mutual Life Insurance Company
P. O. Box 281709
Nashville, TN 37228

Please Print

Name of patient _____ Date of Birth _____
Month Day Year

Patient's address _____
Street City State Zip Code

1. History

a. When did symptoms first appear or accident happen? Month _____ Day _____ Year _____
b. Date patient ceased work because of disability. Month _____ Day _____ Year _____
c. Has patient ever had same or similar condition? ☐ Yes ☐ No If "yes" state when and describe
_____
_____
d. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
e. If condition due to automobile accident, indicate state in which it occurred _____
f. Names and addresses of other treating physicians _____
_____

2. Diagnosis

a. Date of last examination Month _____ Day _____ Year _____
b. Diagnosis (including any complications) _____
_____
c. If disability is due to pregnancy what is expected was delivery date? Month _____ Day _____ Year _____
d. Please describe any complications that would extend this disability longer than for a normal pregnancy. _____
_____
e. Subjective symptoms _____
f. Objective findings (including current X-rays, EKGs, Laboratory Date and any Clinical findings) _____
_____

3. Date of Treatment

a. Date of first visit Month _____ Day _____ Year _____
b. Date of last visit Month _____ Day _____ Year _____
c. Frequency Weekly ☐ _____ Monthly ☐ _____ Other (specify) ☐ _____
d. How long was or will patient be continuously totally disabled *(unable to work)*? Month _____ Day _____ Year _____
e. How long was or will patient be partially disabled? Month _____ Day _____ Year _____

4. Nature of treatment (including surgery and medication prescribed, if any) _____
_____
a. Charges for this procedure and date performed. _____

5. Progress

a. Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
b. Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confinement?
c. Has patient been hospital confined? ☐ Yes ☐ No If "yes" give name and address of hospital? _____
_____Confined from _____through _____

6. Cardiac (if applicable)

a. Functional capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
(American Heart Association) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
b. Blood pressure (last visit) _____ Systolic _____ Diastolic _____

Date	Name of Attending Physician (please print)	Phone Number	Tax ID Number

Address	City or Town	State	Zip Code

Signature of Attending Physician _____

ASSIGNMENT OF INSURANCE BENEFIT: I hereby authorize payment directly to the above named doctor of the Surgical Benefits otherwise payable to me but not to exceed the doctor's regular charges for this surgical procedure. I understand I am responsible to the doctor for charges not covered by this assignment.

Date _____ Patient's Signature _____