

Total Disability - Waiver of Premium Claim

Initial review Yearly review

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LIFEWISE

ASSURANCE COMPANY

Life | Disability | Stop Loss

GROUP NAME
GROUP NUMBER

All information is to be provided at the insured's expense

NAME	SOCIAL SECURITY NUMBER	BIRTHDATE
NATURE OF DISABILITY ON WHICH CLAIM IS BASED?		DATE OF TOTAL DISABILITY?
WHAT WAS YOUR OCCUPATION WHEN YOU BECAME DISABLED?	PREVIOUS OCCUPATIONS?	
WHEN DID YOU LAST DO ANY WORK OR ENGAGE IN ANY OCCUPATION FOR REMUNERATION OR PROFIT?		
NAME AND ADDRESS OF YOUR EMPLOYER		
NAMES AND ADDRESS OF ATTENDING PHYSICIANS		DATES OF TREATMENT
NAME AND ADDRESS OF HOSPITAL IF YOU HAVE BEEN CONFINED		DATES OF CONFINEMENT
LIST ALL MEDICATIONS - DOSES AND FREQUENCY		
WHAT ARE YOUR DAILY ACTIVITIES?		
DESCRIBE WHAT PREVENTS YOU FROM WORKING		
LIST ANY AGENCIES PAYING LOSS OF INCOME BENEFITS IN WHICH YOU ARE INSURED		
NAME AND RELATIONSHIP OF BENEFICIARY		SOCIAL SECURITY NUMBER
ADDRESS OF BENEFICIARY (STREET CITY, STATE, AND ZIP CODE)		TELEPHONE ()
<p>I hereby certify that the foregoing answers are true and correct to the best of my knowledge and belief.</p> <p style="text-align: center;">Authorization to Release Information</p> <p>I request and authorize any provider of health care, agent, insurance company, physician, or hospital having knowledge of information or records relating to my claim for insurance benefits with LIFEWISE ASSURANCE COMPANY to disclose and furnish any information or records including drug, alcohol or psychiatric, required by the Company for the purpose of evaluating and processing my claim to LIFEWISE ASSURANCE COMPANY or its representatives.</p> <p>I understand my right to revoke this authorization by letting LifeWise Assurance Company know of my decision, and to secure a copy of this authorization at any time. A photocopy of this authorization is as valid as the original and will be effective for six months from the date signed below.</p>		
DATE	TELEPHONE NUMBER ()	CLAIMANT'S SIGNATURE
ADDRESS	STREET	CITY
		STATE
		ZIP CODE
FORM WILL BE RETURNED FOR UNANSWERED QUESTIONS		
Opposite Side is for Attending Physician's Statement		

TO BE COMPLETED BY ATTENDING PHYSICIAN
ALL INFORMATION TO BE PROVIDED AT THE INSURED'S EXPENSE

1. PRESENT CONDITION

DIAGNOSIS _____
 DATE OF LAST VISIT _____ FREQUENCY OF VISITS _____
 SUBJECTIVE SYMPTOMS _____
 OBJECTIVE FINDINGS (X-RAYS, EKG'S LABORATORY DATA AND ANY CLINICAL FINDINGS) _____

2. PROGRESS

(A) HAS PATIENT RECOVERED? IMPROVED? UNCHANGED? RETROGRESSED?
 (B) IS PATIENT BED CONFINED? HOSPITAL CONFINED? AMBULATORY? HOUSE CONFINED?
 (C) HAS PATIENT BEEN HOSPITAL CONFINED? YES NO IF YES, GIVE NAME AND ADDRESS OF HOSPITAL _____
 CONFINED FROM _____ THROUGH _____

3. LIMITATION (IF THERE IS A LIMITATION, CHECK AND DESCRIBE BELOW, PLEASE BE SPECIFIC)

STANDING _____ CLIMBING _____ BENDING _____ USE OF HANDS _____ SITTING _____
 WALKING _____ STOOPING _____ LIFTING _____ PSYCHOLOGICAL (SEE # 4) _____
 OTHER (STATE WHICH) _____

4. MENTAL/NERVOUS IMPAIRMENT (IF APPLICABLE)

PLEASE DEFINE "STRESS" AS IT APPLIES TO THIS CLAIMANT.
 CLASS 1 - PATIENT IS ABLE TO FUNCTION UNDER STRESS AND ENGAGE IN INTERPERSONAL RELATIONS (NO LIMITATIONS)
 CLASS 2 - PATIENT IS ABLE TO FUNCTION IN MOST STRESS SITUATIONS AND ENGAGE IN MOST INTERPERSONAL RELATIONS (SLIGHT LIMITATIONS)
 CLASS 3 - PATIENT IS ABLE TO ENGAGE IN ONLY LIMITED STRESS SITUATIONS OR ENGAGE IN INTERPERSONAL RELATIONS (MODERATE LIMITATIONS)
 CLASS 4 - PATIENT IS UNABLE TO ENGAGE IN STRESS SITUATIONS OR ENGAGE IN INTERPERSONAL RELATIONS (MARKED LIMITATIONS)
 CLASS 5 - PATIENT HAS SIGNIFICANT LOSS OF PSYCHOLOGICAL, PHYSIOLOGICAL, PERSONAL AND SOCIAL ADJUSTMENT (SEVERE LIMITATIONS)
 REMARKS :

IS PATIENT NOW TOTALLY DISABLED (UNABLE TO WORK) FOR:

CLAIMANT'S USUAL OCCUPATION? FROM: _____ THRU _____
 ANY OCCUPATION? FROM: _____ THRU _____

WHAT DUTIES IS PATIENT UNABLE TO PERFORM?

WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE?

1-3 MONTHS 6-12 MONTHS NEVER
 3-6 MONTHS >12 MONTHS

TERMINAL?

<12 MONTHS >24 MONTHS
 12 - 24 MONTHS

5. REHABILITATION (COMPLETE THIS SECTION IF ABOVE BOX INDICATES CHANGE IN THE NEXT 12 MONTHS)

(A) IS PATIENT A SUITABLE CANDIDATE FOR FURTHER REHABILITATION SERVICES? YES NO
 (B) CAN PRESENT JOB BE MODIFIED TO ALLOW FOR HANDLING WITH IMPAIRMENT? YES NO
 (C) WHEN COULD TRIAL EMPLOYMENT COMMENCE? PATIENT'S JOB ANY OTHER WORK
 MO. _____ DAY _____ YR. _____ MO. _____ DAY _____ YR. _____
 FULL-TIME PART-TIME FULL-TIME PART-TIME
 (D) WOULD VOCATIONAL COUNSELING AND/OR RETRAINING BE RECOMMENDED? YES NO

PATIENT RELEASED TO WORK:

PART-TIME? YES NO DATE RELEASED: _____ FULL-TIME? YES NO DATE RELEASED: _____

REMARKS:

PHYSICIAN'S FULL NAME (TYPE OR PRINT)

SPECIALTY	PHONE NO.	FAX NO.
ADDRESS	CITY	STATE
		ZIP
SIGNATURE (NO STAMP)	E-MAIL ADDRESS	DATE