

ASSURITY LIFE INSURANCE COMPANY  
APPLICATION FOR INDIVIDUAL BENEFITS

PO Box 80926  
Lincoln, NE 68501

Toll Free 866-289-7337  
Fax 402-437-4592

1. Name of Policyowner \_\_\_\_\_ Policy Number(s) \_\_\_\_\_  
Last First Middle
2. Name of Patient (if different from policyowner) \_\_\_\_\_
3. Business or occupation \_\_\_\_\_
4. Employer's name \_\_\_\_\_  
Employer's address \_\_\_\_\_
5. When did the physician first treat you? \_\_\_\_\_  
Give other dates of treatment \_\_\_\_\_
6. Name of treating physician(s) \_\_\_\_\_  
Physician(s) address \_\_\_\_\_
7. If accident, when did it happen? \_\_\_\_\_, 200\_\_\_\_. Time of day \_\_\_\_\_  
How and where did accident happen? \_\_\_\_\_
8. If sickness, when did it begin? \_\_\_\_\_  
Nature of illness \_\_\_\_\_  
If sickness, have you ever had this same illness before? Yes No  
When? \_\_\_\_\_ Name and address of physician \_\_\_\_\_
9. Are you or will you be applying for benefits under any State or Federal Worker's Compensation law? Yes No  
Please give name and address of the Worker's Compensation insurance carrier \_\_\_\_\_
10. Are you or will you be applying for benefits under any other accident, health, or hospital insurance plan? Yes No  
Please list the names and addresses of other insurance companies \_\_\_\_\_
11. Were you confined to a hospital? Yes No Was an operation performed? Yes No  
Date entered \_\_\_\_\_ Date discharged \_\_\_\_\_  
Name of hospital \_\_\_\_\_  
Address of hospital \_\_\_\_\_

If you are applying for DISABILITY BENEFITS

12. On what date did you stop performing all of your employment duties? \_\_\_\_\_
13. When did or do you expect to return to some of your employment duties? \_\_\_\_\_
14. When did or do you expect to return to all of your employment duties? \_\_\_\_\_

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

I hereby agree to reimburse Assurity to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(cies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

SIGNATURE OF POLICYOWNER \_\_\_\_\_ Date \_\_\_\_\_

If you need to have copies of itemized bills, please make your copies before submitting claims.

CLAIM FORM FAXED ON \_\_\_\_/\_\_\_\_/\_\_\_\_

