

SECTION I MUST BE COMPLETED BY THE CLAIMANT/PATIENT CONTINUED

COMPLETE ONLY IF YOU ARE APPLYING FOR WEEKLY INCOME DISABILITY BENEFITS (VOLUNTEER GROUP MEMBERS ONLY) PLEASE COMPLETE SECTION II & III

21. I was (have been) unable to work because of this disability starting on _____

22. I returned (will return) to work on _____

23. Is the insured covered by the Indiana Workers' Compensation and Workers' Occupational Diseases' Acts? { Yes { No If "Yes", and some medical expenses were denied by the insurer under these Acts, please submit copies of the expenses, both paid and denied as well as copies of the denial letter(s), for our consideration. If "No", and the insured is a volunteer firefighter or a volunteer EMT of a volunteer fire company, please explain why he or she is not covered under by these Acts. _____

24. I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give SPECIAL RISKS HEALTH, Columbus Ohio, or it legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

25. Date ____/____/____ 26. Signature of Patient X _____ 27. Phone () _____
(Parent or Guardian, if minor)

SECTION II TO BE COMPLETED IN FULL BY THE PATIENT'S DOCTOR. Note: Applies only to Disability Benefits

1. Name of Patient _____ 2. Date of Illness (first symptom) or Injury (accident) _____

3. Diagnosis or Symptoms _____

4. Date first consulted you for this condition ____/____/____ 5. Has patient ever had the same or similar symptoms? { Yes { No

6. Date patient able to return to work ____/____/____ 7. Dates of Total Disability: From ____/____/____ Through ____/____/____

8. Progress
(a) Has Patient { Recovered? { Improved? { Not Changed? { Retrogressed?
(b) Is Patient { Ambulatory? { Bed confined? { House confined? { Hospital confined?

9. Prognosis His or Her Job? Any other job?*

(a) is patient now capable of performing duties of? { Yes { No { Yes { No

(b) what duties of his or her job is patient incapable of performing? _____

(c) Do you expect a fundamental or marked change in the future? { Yes { No { Yes { No

(1) If Yes, patient should recover sufficiently to perform duties on or about ____/____/____

(2) If No, please explain _____

*for which he or she is reasonably suited or qualified by education, training or experience

Doctor's Name Degree () Telephone Number

Street Address City or Town State Zip

Date 5 _____
Signature

SECTION III TO BE COMPLETED IN FULL BY THE PATIENT'S EMPLOYER.

1. Name of Employee _____ 2. Social Security No. _____

3. Employee's Date of Hire ____/____/____ 4. Last day worked ____/____/____

5. Reason for stopping work _____ 6. Returned to work on0 ____/____/____ 7. Occupation at time of disability _____

8. Work schedule at the time of disability Days per week _____ Hours per day _____

Employer _____ Address _____
Date ____/____/____ Signed _____ Title _____ Tel No () _____

SECTION IV ASSIGNMENT OF MEDICAL EXPENSE BENEFITS -

I Authorize Special Risks Health Department to pay medical expense benefits in connection with this claim directly to the doctor, hospital, or other supplier.

1. Date ____/____/____ 2. Signature of Patient _____
(Parent or Guardian, if minor)

SECTION V VOLUNTEER GROUP CERTIFICATION

I certify that the above information is correct to the best of my knowledge and belief, that the person named in item 2 is insured by the policy, and that his or her insurance was in effect on the date of the covered activity involved.

1. Date ____/____/____ 2. Signed X _____ 3. Title _____

4. Policy Number _____ 5. Phone () _____