DISABILITY CLAIM FORM
MORTGAGE INSURANCE

First National Life Insurance Company of the USA
Since 1908
A nelnet COMPANY

P.O. Box 6278
Lincoln, NE 68506
T. 800.383.1776
F. 402.483.2341

TO BE COMPLETED BY LENDING INSTITUTION

NAME OF INSURED			AGE
First	M.I.	Last	
ADDRESS OF INSURED		INITIAL AMOUNT	LOAN NUMBER
Street	City	State	
GROUP POLICY NUMBER	CERTIFICATE NUMBER	LOAN DATE	MONTHLY PAYMENT
POLICY EFFECTIVE DATE	POLICY TERMINATION DATE	IS INSURANCE NOW IN FORCE? ☐ Yes ☐ No	IF NO, GIVE TERMINATION DATE
LENDING INSTITUTION		BY	
ADDRESS		TITLE	DATE
Street	City	State	

TO BE COMPLETED BY INSURED DEBTOR

DATE ACCIDENT OCCURED OR SICKNESS BEGAN.	Date	
IN YOUR OWN WORDS, DESCRIBE NATURE OF INJURY OR SICKNESS. IF AN ACCIDENT, WHEN AND HOW DID IT HAPPEN?		
NAMES AND ADDRESSES OF ATTENDING PHYSICIANS.	Names	Addresses
WAS HOSPITAL CONFINEMENT REQUIRED? IF YES, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.	☐ Yes ☐ No	
	Hospital	City and State
	From	To
HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? IF YES, GIVE DATES AND NAMES OF ATTENDING PHYSICIANS.	☐ Yes ☐ No	
	Attending Physician(s)	Date(s)
NAME AND ADDRESS OF EMPLOYER	Name	Address
DATE YOU WERE COMPLETELY UNABLE TO WORK BECAUSE OF THIS CONDITION	Date	
DATE FIRST ABLE TO PERFORM SOME OF THE DUTIES OF EMPLOYMENT	Date	
DATE RETURNED TO FULL-TIME EMPLOYMENT	Date	

I certify that the above statements and answers are correct and complete. 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 records or knowledge of me, my health, or my family and their health, to give to the First National Life Insurance Company of the U.S.A., any such information. A photographic copy of this authorization shall be as valid as the original.

DATE

SIGNATURE OF INSURED DEBTOR

NOTE: PHYSICIAN'S STATEMENT ON THE OTHER SIDE

HEALTH INSURANCE CLAIM—GROUP OR INDIVIDUAL—DISABILITY INCOME

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS		DATE OF BIRTH
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of the examination of my treatment.	SIGNED (PATIENT)	DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS AND CONCURRENT CONDITIONS	
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No	PREGNANCY? ☐ Yes ☐ No
DATES OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT)	
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF YES, WHEN AND DESCRIBE ☐ Yes ☐ No	**PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?** ☐ **Yes** ☐ **No** **PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)** **FROM** **THRU**
PATIENT WAS PARTIALLY DISABLED FROM THRU	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
PATIENT WAS HOUSE CONFINED FROM THRU	
DOES PATIENT HAVE OTHER HEALTH COVERAGE? IF "YES", PLEASE IDENTIFY ☐ Yes ☐ No	

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYEE	
DATE EMPLOYEE FIRST UNABLE TO WORK	DATE
DATE RETURNED TO PART-TIME WORK	DATE
DATE RETURNED TO FULL-TIME WORK	DATE
IF STILL OFF WORK, DATE YOU EXPECT EMPLOYEE TO RETURN	DATE

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	BY	TITLE	DATE