

**SUPPLEMENTARY CLAIM FORM
MORTGAGE INSURANCE**



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

TO BE COMPLETED BY INSURED DEBTOR This form should be completed on _____ or upon return to work, if sooner.

Name of insured debtor Address	_____ Phone _____ Street _____ City _____ State _____ Zip Code _____
Name of employer Address	_____ Phone _____ Street _____ City _____ State _____ Zip Code _____
What is your condition at this time?	_____
On what dates have you been treated by a physician since last report?	Dates _____
Have you been hospitalized or undergone surgery since your last report? If yes, name and address of hospital or doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____
On what date were you able to resume to work part time?	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

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.	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> </div> <div style="text-align: center;">SIGNED (PATIENT)</div> <div style="text-align: center;">DATE</div> </div>

PART B ATTENDING PHYSICIAN'S STATEMENT

(1) Nature of sickness or injury. (Describe complications, if any)	
(2) Is condition due to pregnancy? If yes, what was approximate date of commencement of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date _____, 20 _____
(3) When did symptoms first appear or accident happen?	Date _____, 20 _____
(4) When did patient first consult you for this condition?	Date _____, 20 _____
(5) Has patient ever had same or similar condition? (If yes, state when and describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(6) Describe any other disease or infirmity affecting present condition	
(7) Nature of surgical or obstetrical procedure, if any (describe fully) and date performed Where performed?	_____ _____ Date _____, 20 _____ _____ If in hospital, in patient <input type="checkbox"/> out patient <input type="checkbox"/>
(8) Give dates of treatment	Office _____ Home _____ Hospital _____
(9) Is patient still under your care for this condition? If discharged, give a date	<input type="checkbox"/> Yes <input type="checkbox"/> No Date _____, 20 _____
(10) If patient hospitalized, give name and address of hospital	Hospital _____ City _____ State _____ Date Admitted _____, 20 _____ Date Discharged _____, 20 _____
(11) How long was or will patient be continuously totally disabled (unable to work)?	From _____, 20 _____ To _____, 20 _____
(12) If accident, how long was or will patient be partially disabled?	From _____, 20 _____ To _____, 20 _____
(13) If sickness, was patient confined to the house? (if yes, give dates)	<input type="checkbox"/> Yes <input type="checkbox"/> No From _____, 20 _____ To _____, 20 _____
(14) Is condition due to injury or sickness arising out of patient's employment? If yes, explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	