SUPPLEMENTARY CLAIM FORM
CREDIT 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 after ____________ 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	☐ Yes ☐ 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.	SIGNED (PATIENT)	DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

Question	Answer
(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?	☐ Yes ☐ 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)	☐ Yes ☐ 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 ☐ out patient ☐
(8) Give dates of treatment	Office ____________ Home ____________ Hospital ____________
(9) Is patient still under your care for this condition? If discharged, give a date	☐ Yes ☐ 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 sickness, was patient confined to the house? (if yes, give dates)	☐ Yes ☐ No From ____________, 20 ____ To ____________, 20 ____
(13) Is condition due to injury or sickness arising out of patient's employment? If yes, explain.	☐ Yes ☐ No

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE