

**INVESTORS HERITAGE Life Insurance Company**

P.O. BOX 717, FRANKFORT, KENTUCKY 40602

**STATEMENT OF INSURED PATIENT**

**BEFORE PROCESSING OF YOUR CLAIM CAN BEGIN, YOU MUST RETURN THE STATEMENT OF INSURED PATIENT ALONG WITH THE ATTENDING PHYSICIAN'S STATEMENT AND A COPY OF YOUR CREDIT A&H POLICY TO THE ABOVE ADDRESS.**

**PART A**

**PLEASE ANSWER ALL QUESTIONS**

Your Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Your Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Have you filed a claim with Investors Heritage before?  Yes  No Social Security No. \_\_\_\_\_

Your occupation \_\_\_\_\_ Home Phone No. (\_\_\_\_) \_\_\_\_\_

Describe your duties \_\_\_\_\_ Average monthly earnings \$ \_\_\_\_\_

Supervisor \_\_\_\_\_

Name and address of your Employer \_\_\_\_\_

Telephone No. (\_\_\_\_) \_\_\_\_\_ When did you cease work? \_\_\_\_\_, 19\_\_\_\_ Time \_\_\_\_\_

When did you or do you expect to return to work? \_\_\_\_\_

Phone No. where you can be reached during the day (\_\_\_\_) \_\_\_\_\_

1. Is your disability caused by:  Injury?  Sickness? Please explain in detail, Nature of Sickness or Injury, give date, place and circumstances.

\_\_\_\_\_

2. If Sickness, when did symptoms appear? \_\_\_\_\_, 19\_\_\_\_

3. If you were hospitalized, give name and address of Hospital and date of confinement.

\_\_\_\_\_

4. Have you ever had this or a similar condition before?  Yes  No If yes, give date \_\_\_\_\_

5. What doctors have treated you for any sickness or accident in the last 3 years?

(A) Name and complete address of doctor (B) Why were you treated? (C) Date you were treated

\_\_\_\_\_

6. Are you receiving or have you received disability pension or compensation?  Yes  No

Date of first payment \_\_\_\_\_, 19\_\_\_\_ From whom: \_\_\_\_\_

7. Have you applied for Social Security Benefits:  Yes  No If yes, date \_\_\_\_\_

8. Are you receiving or have you received workers' compensation?  Yes  No From whom: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL AND EMPLOYMENT INFORMATION**

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Veteran's Administration, the Medical Information Bureau, Inc., my employer, consumer reporting agency or insurance or reinsuring company who possess information on the care, treatment or advice of me to furnish such information to INVESTORS HERITAGE LIFE INSURANCE COMPANY, hereinafter called the company or its legal representative upon presenting this Authorization or a photocopy. The Company, its reinsurers, insurance support organizations and their authorized representatives, may obtain medical and other information, in order to determine eligibility for benefits under an existing policy. The Authorization shall include information concerning drugs, alcoholism or mental illness. I understand that the Company or its reinsurers may make a brief report concerning me to other insurance companies to determine eligibility for benefits under an existing policy. I authorize the Company to obtain an investigative consumer report on me if necessary to determine eligibility for benefits under an existing policy. I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for the duration of any claim from the date shown below. I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement is guilty of insurance fraud. The above statements are true and correct to the best of my knowledge and belief.

**IF ALL QUESTIONS ON THIS FORM ARE NOT COMPLETED IN FULL IT MAY CAUSE A DELAY IN YOUR CLAIM. YOU ARE RESPONSIBLE FOR LOAN PAYMENTS AND ANY LATE CHARGES WHILE YOUR CLAIM IS BEING PROCESSED.**

Date \_\_\_\_\_, 19\_\_\_\_ Signature \_\_\_\_\_

**PART B**

**STATEMENT OF FINANCIAL INSTITUTION  
THIS SECTION TO BE COMPLETED BY THE LENDING INSTITUTION  
ATTACH COPY OF POLICY FACE WITH FIRST CLAIM**

Name of Insured \_\_\_\_\_ Amount of Policy \_\_\_\_\_ Policy No. \_\_\_\_\_

Date of Loan \_\_\_\_\_ Term \_\_\_\_\_ Have previous claims been filed for this person?  Yes  No

30 day Retro \_\_\_\_\_ 14 Day Retro \_\_\_\_\_ 30 Day Elm. \_\_\_\_\_ 14 Day Elm. \_\_\_\_\_

Name of authorized Representative (Please Print) \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

Financial Institution \_\_\_\_\_

Street Address

City/Town

State

Zip Code

Dealership Name (if any) \_\_\_\_\_

**PART C**

**EMPLOYER'S STATEMENT**

Employee's Name \_\_\_\_\_

Was he/she a full or part-time employee at beginning of this disability?  Full-time  Part-time

Was he/she laid off prior to beginning of disability?  Yes  No If so, on what date \_\_\_\_\_

Date Employee last worked \_\_\_\_\_

Date Employee resumed any part of his work, supervisory or otherwise \_\_\_\_\_

Was injury or disease covered under workmen's compensation?  Yes  No

Name & Address of your compensation carrier \_\_\_\_\_

Name of Employer \_\_\_\_\_ Phone No. \_\_\_\_\_  
Company or Corporation Area Code

Address \_\_\_\_\_ Signature of Authorized Signer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_