

# Foundation Life Insurance Company of Arkansas

109 North 6th ST  
Fort Smith, AR 72901  
(479)785-1714 or 1-800-446-2214

**Instructions:** A Claim Report must be completed in its entirety by the Attending Physician, Employer, and the Insured at the end of each 30 day period of disability, or when the insured resumes work, whichever occurs first. Return this fully completed report to this Company at the address above.

## CLAIMANT'S STATEMENT

Bank name that holds loan:				
Policy owner's full name:				
Policy No.	Policy Date	Agent's Name		
Policy owner's phone number:		Date of Birth	Height	Weight
What sickness or injury was suffered?				
On what date did you first notice that you were beginning to get sick, or what was date of injury?		At what date and time did accident causing injury occur?		,20
On what date were you first treated by a physician for this sickness or injury?				,20
Please list first date you did not work because of this sickness or injury.				,20
<b>IF DISABILITY IS DUE TO SICKNESS ANSWER QUESTIONS 1-4</b>				
1. Have you ever been afflicted with this condition before?	If so, when?			,20
2. On what date were you first confined to the house all day?				,20
3. On what date were you first able to leave the house for any purpose?				,20
4. On what date were you first able to do any part of your work, supervisory or otherwise?				,20
<b>IF DISABILITY IS DUE TO INJURY ANSWER QUESTIONS 5-8</b>				
5. How did the accident occur?				
6. On what date were you first able to do any part of your work, supervisory or otherwise?				,20
7. What duties are you now unable to perform due to this injury?				
8. On what date did you resume your regular duties?				,20
Have you had any medical or surgical advice during the past five years for any other condition?	For what?	When?	,20	
	Physician's Name and address			
Has any other physician treated you for this accident or sickness?	If so, when?	Physician's Name _____ Address _____		
What is your occupation?	Monthly Salary \$			
Name and address of your employer.				

I hereby certify the foregoing statement to be true and correct. I agree that any statement herein made by me and found by the Company to be false, shall render all rights under my policy voidable at the option of the Company. Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and imprisonment.

I hereby direct the Company to pay all benefits accruing to me as a result of the above described disability to the first beneficiary of my above mentioned policy. I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish any and all information to Foundation Life Insurance Company of Arkansas, or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date \_\_\_\_\_, 20\_\_\_\_ Insured's Signature \_\_\_\_\_

Address \_\_\_\_\_  
(Street and No.) (City) (State) (Zip Code)