

Foundation Life Insurance Company of Arkansas

109 N. 6th ST
Fort Smith, AR 72901

Continuing Accident and Health Claim

In order for further disability benefits to be considered, this form will need to be completed in its ENTIRETY and returned to the above address. Please be sure the form is signed and dated by the Insured AND their Doctor.

TO BE COMPLETED BY THE INSURED:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
City/State/Zip: \_\_\_\_\_

- 1. Are you able to perform the duties of your OWN occupation? \_\_Yes \_\_No, or ANOTHER occupation? \_\_Yes \_\_No
2. Have you returned to work? \_\_\_\_Yes \_\_\_\_No If YES, give date you returned: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. List all dates of medical treatment since last report: \_\_\_\_\_
4. What prevents you from returning to work at this time? \_\_\_\_\_

These statements are true and complete to the best of my knowledge and belief. I authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning me to furnish such records, data, or information to FOUNDATION LIFE INSURANCE COMPANY OF ARKANSAS, or its authorized representatives as requested. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original for the duration of my claim.

Date: \_\_\_\_\_ Signature of Insured: \_\_\_\_\_
Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

- 1. Nature of sickness or injury (Describe complications, if any): \_\_\_\_\_
3. Please describe present treatment and dates since last report: \_\_\_\_\_
4. How long was or will patient be continuously totally disabled? \_\_\_\_\_
(Note: We do not issue benefits for partial disability.)
5. If return to work date is unknown, please estimate: \_\_less than 3 mo. \_\_3 to 6 mo. \_\_6 to 12 mo. \_\_over 24 mo.

Date: \_\_\_\_\_ Signature of Attending Physician: \_\_\_\_\_
Type/Print Physician's Name: \_\_\_\_\_
Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
(Street Address)

(City or Town) (State) (Zip)

TO BE COMPLETED BY THE EMPLOYER:

- 1. Has insured returned to work? \_\_\_\_\_
If yes, please provide date returned. \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_\_ Signature of Employer: \_\_\_\_\_
Phone: ( ) \_\_\_\_\_