ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

INSURED EMPLOYEE'S AND EMPLOYER'S STATEMENT

PART I. TO BE COMPLETED BY INSURED EMPLOYEE IN FULL

1a.	NAME OF INSURED EMPLOYEE	1b.	DATE OF BIRTH	1c.	SEX	1d.	HEIGHT	1e.	WEIGHT
1f.	HOME ADDRESS STREET CITY STATE ZIP	1g.	PHONE (AREA)						
2.	OCCUPATION AND BRIEF DESCRIPTION OF DUTIES								
3a.	NATURE OF SICKNESS OR INJURY	3b.	DATE OF SICKNESS OR INJURY	3c.	DATE OF FIRST TREATMENT				
3d.	IF INJURY, HOW AND WHERE DID ACCIDENT HAPPEN?	3e.	IS THE INJURY OR SICKNESS EMPLOYMENT RELATED? ☐ YES ☐ NO						
4a.	NAME OF ATTENDING PHYSICIAN(S)	4b.	ADDRESS						
5a.	NAME OF HOSPITAL WHERE CONFINED	5b.	ADDRESS						
5c.	DATE(S) OF HOSPITAL CONFINEMENT	5d.	WAS THERE EVER PRIOR TREATMENT FOR OR DISABILITY FROM THIS SAME OR SIMILAR CONDITION? ☐ YES ☐ NO						
5e.	IF "YES," DATES, NAMES AND ADDRESSES OF PRIOR PHYSICIANS AND HOSPITALS								
6a.	ARE BENEFITS PAYABLE FOR THIS CLAIM UNDER ANY OTHER DISABILITY PLANS? ☐ YES ☐ NO								
6b.	IF "YES," GIVE NAME AND ADDRESS OF INSURANCE COMPANY	6c.	POLICY NO.						
7a.	BECAUSE OF THIS ACCIDENT OR SICKNESS, WHEN DID YOU FIRST LEAVE WORK? DATE HOUR A.M. P.M.	7b.	WHEN DID YOU FIRST RETURN TO WORK? PART WORK FULL WORK						
7c.	WHAT DUTIES DID YOU RESUME?								
7d.	IF STILL DISABLED, WHEN DO YOU PLAN TO RESUME WORK? PART WORK FULL WORK	7e.	WHAT WAS YOUR MONTHLY INCOME PRIOR TO DISABILITY?						
8.	I AM CLAIMING _____ NUMBER DAYS OF TOTAL DISABILITY FROM ___/___/___ MO. DAY YR. TO ___/___/___ MO. DAY YR.								
	I AM CLAIMING _____ NUMBER DAYS OF PARTIAL DISABILITY FROM ___/___/___ MO. DAY YR. TO ___/___/___ MO. DAY YR.								

Notice: Your signature and date on this form indicates that you acknowledge the fraud warning applicable in your state as indicated on the attached page.

Date _____, 20____ X _____
Signature of Claimant

DO NOT DELAY RETURNING THIS FORM WHILE WAITING FOR PHYSICIAN TO COMPLETE DISABILITY INCOME PHYSICIAN'S STATEMENT

PART II. TO BE COMPLETED BY EMPLOYER IN FULL

1a.	NAME OF EMPLOYER			1b.	GROUP POLICY NO. CERTIFICATE NO.
1c.	EMPLOYER'S ADDRESS STREET CITY STATE ZIP			1d.	PHONE (AREA)
2.	NAME OF INSURED EMPLOYEE				
3a.	# OF HOURS WORKED PER WEEK PRIOR TO DISABILITY	3b.	DATE EMPLOYED	3c.	% OF PREMIUM PAID BY EMPLOYER
4a.	DATE EMPLOYEE CEASED TO WORK	4b.	DATE RETURNED TO WORK	4c.	IS THE INJURY OR SICKNESS EMPLOYMENT RELATED? ☐ YES ☐ NO
5a.	IS THE EMPLOYEE RECEIVING ANY OTHER BENEFITS (I.E. DISABILITY, RETIREMENT OR SOCIAL SECURITY)? ☐ YES ☐ NO				
5b.	IF "YES," GIVE NAME AND ADDRESS OF CARRIER				
6.	ANNUAL INCOME, OR COPY OF LAST W-2				

PART III. JOB ANALYSIS (TO BE COMPLETED BY EMPLOYER)

1.	OCCUPATION/JOB TITLE
2.	IMPORTANT JOB DUTIES, OR PROVIDE COPY OF THE COMPLETE JOB DESCRIPTION IF AVAILABLE.
3.	PHYSICAL DEMANDS (HOURS PER DAY) STANDING _____ CARRYING _____ SITTING _____ PUSHING _____ WALKING _____ PULLING _____ BENDING _____ DRIVING _____ LIFTING _____ OUTSIDE _____
4.	MACHINES, TOOLS AND EQUIPMENT USED OR OTHER JOB HAZARDS
5.	COMMENTS

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Date _____ Signed _____

Employee's SS No. _____ Title _____

GENERAL FRAUD STATEMENT: 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 confinement in prison.

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For residents of Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of Arkansas, Louisiana, Rhode Island, and West Virginia: 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 confinement in prison.

For residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

For residents of Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Georgia: 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, may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For residents of Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For residents of Kansas: 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, may be guilty of insurance fraud as determined by a court of law.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: 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, may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 309.674.8255

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DISABILITY INCOME PHYSICIAN'S STATEMENT

TO BE COMPLETED BY INSURED

Benefits Fax (309) 673-8137

Policy Number		Claim Number	
1a.	PATIENT'S NAME (First name, middle initial, last name)	1b.	DATE OF BIRTH
2.	ADDRESS STREET CITY STATE ZIP		
3.	PATIENT'S SIGNATURE I authorize the release of any medical information necessary to process my claim. SIGNATURE _____ DATE _____		

TO BE COMPLETED BY ATTENDING PHYSICIAN

4.	DATE CONDITION BEGAN: ☐ ILLNESS (First symptom) ☐ INJURY (Accident) ☐ PREGNANCY (LMP)		
5.	DATES OF TREATMENT BY YOU: 1. First Treatment: _____ 2. All Other Dates: _____	6.	WAS SURGERY PERFORMED? ☐ YES ☐ NO Date of Surgery: _____ Procedure: _____
7.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:		
8.	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO IF YES, PLEASE PROVIDE DETAILS:		
9.	NAME & ADDRESS OF REFERRING PHYSICIAN:		

10a.	DATES OF TOTAL DISABILITY FROM HIS/HER OCCUPATIONAL DUTIES: From _____ To: _____	10b.	DATES OF PARTIAL DISABILITY: From _____ To: _____	10c.	ANTICIPATED LENGTH OF DISABILITY:
10d.	PLEASE PROVIDE RESTRICTIONS/LIMITATIONS:				
11.	NAME, ADDRESS AND POLICY NUMBERS OF OTHER INSURANCE CARRIERS:				
12.	HAS PATIENT BEEN TREATED BY YOU IN THE PAST? ☐ YES ☐ NO IF YES, PLEASE PROVIDE DETAILS:				
13.	PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT): _____				
14.	PHYSICIAN'S ID NUMBER: _____ PHONE NUMBER (_____) _____ FAX NUMBER (_____) _____				
	Notice: Your signature and date on this form indicates that you acknowledge the fraud warning applicable in your state as indicated on the attached page.				
15.	PHYSICIAN'S SIGNATURE: _____ DATE: _____				

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For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 309.674.8255

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800.437.7355

CLAIM AUTHORIZATION

Claims Fax (309) 673-8137

Claimant's Name:	Claim Number:
Claimant's Address:	Claimant's Date of Birth:

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, or other medical or medically related facility, Veterans Administration, MIB, Inc., Social Security Administration, employer, consumer reporting agency or insurance company that possesses health information, including prescription history and medications prescribed, or other information about me to furnish all such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its authorized representative, upon presenting this Authorization or a photocopy. Health information includes any medical treatment records which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes. Illinois Mutual Life Insurance Company may specify the name of the practitioner or facility below.

The purpose of this authorization is to provide information about me in order for the Company to review my claim under an existing insurance policy. Treatment, payment, enrollment or eligibility may not be conditioned upon obtaining this authorization. Information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to reinsurers or other parties providing services to the Company who may be involved with my claim. Information obtained by this Authorization may also be re-disclosed by the Company without my authorization as otherwise permitted or required by law. Re-disclosed information may not be protected under federal privacy rules.

I acknowledge that I have read this Authorization and I will receive a copy of it. I understand and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, IL 61634. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company. A photographic copy of this authorization shall be as valid as the original.

_____ Date

_____ Signature of Claimant

(If Claimant is under 18 years of age or is incapacitated, Parent or Guardian must sign. If Claimant is deceased, Personal Representative or next of kin must sign.)

_____ Printed Name of Person Signing Above

_____ Relationship to Claimant

Home Office Use Only: (Please do not complete)

_____ Practitioner or Facility

NOTE TO MEDICAL PROVIDERS: This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also known as HIPAA.