



INSURED'S STATEMENT

Name	Home Phone Number	Policy Number(s)
Business name and address		Business Phone Number
Condition causing your disability		
If still disabled, describe any changes in your condition		
Dates during which you were continuously totally disabled and wholly unable to work at your occupation		
From		Through
During the above period did you visit your place of business? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give reason(s) and frequency of visits		
If you were partially disabled (could perform some, but not all of your occupation), give dates		
From		Through
Name the important daily duties you could NOT perform during the above period of partial disability		
What percentage of your normal duties do the duties you named above (cannot perform) represent? %		
During your period of disability, did you work at ANY other occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give dates and employer's name and address. Also describe occupation, duties performed and income received.		
From		Through
If you are still disabled, when do you expect your disability will end?		
Total disability	_____	
Partial disability	_____	
Since your last claim statement, have you been in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give hospital and dates confined		
Name	_____	
City/State	_____	
Dates	_____	
Since your last claim statement, have you been attended by any other physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give name and address		
Name	_____	
Address	_____	
Are you participating in, or have you considered, a program of rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," describe your program, the hours required and who is sponsoring it		
<p>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 who has attended me or has any records or knowledge of me or my health to furnish the Security Mutual Life Insurance Company of New York, or its representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.</p> <p>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.</p>		
Date	Signed	

TO AVOID DELAY, PLEASE ANSWER ALL QUESTIONS COMPLETELY



ATTENDING PHYSICIAN'S STATEMENT

Patient's Name		Occupation	Age
DIAGNOSIS	Based upon your clinical evaluation, what is patient's diagnosis, including all complications?		
	What are the patient's subjective symptoms?		
	What are the objective findings? (including X-rays, EKG, Lab Data, Clinical Findings, etc.)		
	Is this diagnosis based on the statements of the patient or on your clinical evaluation of the patient?		
	Is there pre-existing and/or co-existing disease which affects present condition? If yes, please explain.		
TREATMENT	List all dates on which treatment has been rendered in the past		
	How often is patient presently being seen?		
	What was the date of patient's last visit?		
	What treatment has patient received, including surgery and medication prescribed?		
PROGRESS	What is patient's degree of recovery? (Fully recovered, improved, unchanged, retrogressed, etc.)		
	Is patient presently ambulatory (with or without restrictions), bed confined, house or hospital confined?		
	Has patient been hospitalized? If yes, give name and address of Hospital and inclusive dates of hospitalization		
PROGNOSIS	Is patient now partially and/or totally disabled from pursuing his/her occupation? If partially disabled, include duties of occupation patient is not able to perform		
	How long has or will patient be partially disabled?	From _____ Date	Through _____ Date
	How long has or will patient be continuously totally disabled?	From _____ Date	Through _____ Date
	Do you expect a fundamental or marked change in patient's condition in the future? If yes, approximately when will patient recover to return to his/her occupation? If no, please explain.		
	Is this prognosis based on the statement of the patient or on your clinical evaluation of the patient?		
Date	Signed		
Street Address	City or town	State	Zip Code