

Group Marketing Services, Inc.
P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611

WEEKLY INDEMNITY BENEFITS CLAIM FORM

EMPLOYEE'S STATEMENT

CLAIMANT'S NAME		SOCIAL SECURITY OR CERTIFICATE NUMBER		PHONE NUMBER	
CLAIMANT'S ADDRESS			CITY		STATE
					ZIP CODE
CLAIMANT'S DATE OF BIRTH	HEIGHT ' "	WEIGHT #	OCCUPATION		
EMPLOYER'S NAME				INITIAL DATE OF INJURY OR SICKNESS	
LAST DAY WORKED	CURRENT WEEKLY EARNINGS \$ (gross); \$ (net)		DATE OF LAST PAYCHECK	AMOUNT \$	

1. Do you expect any other Paycheck(s) from your employer before you return to work? Yes or No

If Yes; Amount(s): \$ _____ Date(s): _____

2. Do you have any other income? Yes or No; If yes, Amount and source: _____

3. Is this condition due to a work related injury? Yes, No, Currently Under Review or Unknown

Has this claim been filed under worker's compensation coverage? Yes or No

IF FILING CLAIM UNDER WORKER'S COMPENSATION, SOCIAL SECURITY, STATE DISABILITY, RETIREMENT, PENSION OR AUTO INSURANCE PLEASE INDICATE CARRIER:

4. Do you have other disability or hospital insurance? Yes or No

IF YES, GIVE COMPANY NAME, ADDRESS, POLICY NUMBER AND AMOUNT:

5. Is this claim due to an Injury, Sickness, Pregnancy or Other, explain; _____

6. Describe Sickness or how and where injury occurred: _____

7. Have you ever had same or similar sickness or injury? Yes or No; If yes, Indicate Dates: _____

COMPLETE THE TREATING PHYSICIAN(S) SECTION;

Physician:	Physician:	Physician:
Address:	Address:	Address:
Treatment Dates	Treatment Dates	Treatment Dates

IF HOSPITAL CONFINED, COMPLETE THE FOLLOWING SECTION;

Hospital:	Hospital:	Hospital:
Address:	Address:	Address:
Confinement Dates	Confinement Dates	Confinement Dates
From: Thru:	From: Thru:	From: Thru:

The following is required in certain states: Any person who, knowingly and with intent to defraud or deceive any insurance company, files statement of claim containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.

Signed: X _____ Dated: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or government agency to disclose or furnish to Assurity Life Insurance Company, its subsidiaries or representatives, any and all information with respect to any illness including mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records that may be requested. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signed: X _____ Dated: _____