

**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): \_\_\_\_\_

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

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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:

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4. Do you have other disability or hospital insurance?  Yes or  No  
IF YES, GIVE COMPANY NAME, ADDRESS, POLICY NUMBER AND AMOUNT:

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

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6. Describe Sickness or how and where injury occurred:  
\_\_\_\_\_  
\_\_\_\_\_

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

**IF HOSPITAL CONFINED, COMPLETE THE FOLLOWING SECTION;**

Hospital: Address:	Hospital: Address:	Hospital: 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: \_\_\_\_\_

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**WEEKLY INDEMNITY BENEFITS**  
**EMPLOYER'S STATEMENT**

EMPLOYER'S NAME: \_\_\_\_\_

EMPLOYEE'S NAME: \_\_\_\_\_

POSITION: \_\_\_\_\_

FULL TIME HIRE DATE: \_\_\_\_\_

LAST DAY WORKED: \_\_\_\_\_

GROSS WEEKLY COMPENSATION: \$ \_\_\_\_\_

NET WEEKLY COMPENSATION: \$ \_\_\_\_\_

DOES COMPENSATION INCLUDE:

BONUS:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

PROFIT SHARING:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

OVERTIME:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

COMMISSIONS:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

OTHER:  NO OR  YES; AMOUNT: \$ \_\_\_\_\_

DESCRIPTION: \_\_\_\_\_

HAS EMPLOYEE COLLECTED ANY WAGES SINCE DISABILITY BEGAN (I.E. VACATION, SICK OR PERSONAL PAY):  YES OR  NO;

AMOUNT: \$ \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

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AMOUNT: \$ \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

PERCENTAGE OF **DISABILITY** PREMIUM EMPLOYEE CONTRIBUTES: \_\_\_\_\_

%; IS CONTRIBUTION DEDUCTED ON A PRE-TAXED BASIS:  YES OR  NO

EMPLOYEE'S DUTIES: \_\_\_\_\_

EMPLOYEE CAN PERFORM JOB DUTIES:  WITH **NO** RESTRICTION

WITH RESTRICTIONS

CANNOT PERFORM

EXPLAIN RESTRICTIONS: \_\_\_\_\_

WHAT JOB DUTIES CAN THIS EMPLOYEE NOT PERFORM DUE TO THEIR CONDITION? \_\_\_\_\_

DOES EMPLOYEE'S RESPONSIBILITIES INCLUDE HEAVY LIFTING OR HEAVY MANUAL LABOR?  YES OR  NO

IS THERE A POSITION AVAILABLE FOR THIS EMPLOYEE IF THEY CAN RETURN TO WORK UNDER RESTRICTED OR LIGHT DUTY?  YES OR  NO

IS THE DISABLING CONDITION DUE TO, OR RELATED TO, THE EMPLOYEE'S EMPLOYMENT?  YES OR  NO

WAS A WORKER'S COMPENSATION CLAIM FILED FOR THIS DISABILITY:  YES OR  NO; IF YES, ATTACH WORKERS COMP CARRIERS DETERMINATION

TOTAL DISABILITY DATES: FROM: \_\_\_\_\_

TO: \_\_\_\_\_

HAS THIS EMPLOYEE BEEN OFFERED: FMLA EXTENSION:  YES OR  NO

COBRA EXTENSION:  YES OR  NO

HAS THIS EMPLOYEE ELECTED: FMLA EXTENSION:  YES OR  NO

COBRA EXTENSION:  YES OR  NO

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.

NAME: \_\_\_\_\_  
(PRINT)

TITLE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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**WEEKLY INDEMNITY BENEFITS**

**PHYSICIAN'S STATEMENT**

PATIENT'S NAME:

PATIENT'S BIRTHDATE:

1. NATURE OF CONDITION:  SICKNESS OR  INJURY OR  PREGNANCY OR  OTHER; EXPLAIN

2. IS THE DISABLING CONDITION DUE TO, OR RELATED TO, THE EMPLOYEE'S EMPLOYMENT?  YES OR  NO

3. DIAGNOSIS:

4. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?

5. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?

6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION:

7. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE IF ANY:

8. DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL:

9. IF HOSPITALIZATION OCCURRED, PROVIDE NAME AND ADDRESS OF FACILITY:

10. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITIONS? IF YES, PLEASE DESCRIBE:

11. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION:  YES OR  NO

12. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?

PLEASE PROVIDE DATES: FROM: TO:

13. PATIENT CAN RETURN TO WORK ON: \_\_\_\_\_  WITH RESTRICTIONS OR  WITH NO RESTRICTIONS

RESTRICTIONS:

I AUTHORIZE THE RELEASE TO ASSURITY LIFE INSURANCE COMPANY OF ANY AND ALL MEDICAL RECORDS PERTAINING TO THE ABOVE PATIENT.

DATE:

SIGNED:

INDIVIDUAL PRACTITIONER'S SS/TIN/NPI #:

DEGREE:

( )

PHONE NUMBER

(CITY / STATE / ZIP)