Group Marketing Services, Inc.

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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	DATE OF LAST PAYCHECK	AMOUNT
	$ (gross); $ (net)		$

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:_____