



Time Insurance Company  
P.O. Box 2829  
Clinton, IA 52733-2829  
1-866-387-0484 (Toll-Free) / 1-608-373-9503(Fax)

**WAIVER OF PREMIUM  
STATEMENT OF CLAIM**

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.

Signature of Patient (If minor, parent/guardian must sign) \_\_\_\_\_ Date \_\_\_\_\_

**PART ONE: INSURED'S STATEMENT: TO BE COMPLETED BY INSURED**

INSURED:		POLICY No.(s)	
ADDRESS:		CITY, STATE, ZIP	
PHONE No.:	BIRTHDATE	SOCIAL SECURITY No.	

Is claim due to an accident?  Yes  No If yes, date of accident: \_\_\_/\_\_\_/\_\_\_ Where did accident occur? \_\_\_\_\_

Please describe how accident occurred: \_\_\_\_\_

Is claim due to a sickness?  Yes  No If yes, when did it begin? \_\_\_/\_\_\_/\_\_\_ State nature of sickness: \_\_\_\_\_

Is this claim the result of a work-related illness or injury?  Yes  No Doctor's name and address: \_\_\_\_\_

Give first date you were unable to work because of this sickness or injury: \_\_\_/\_\_\_/\_\_\_

If you are unable to work due to total disability, when do you expect to return to work? \_\_\_/\_\_\_/\_\_\_

Have you applied for Social Security disability?  Yes  No Has your application been approved?  Yes  No *If yes, please attach a copy of the approval.*

Please review and sign the attached authorization. Two copies are attached: return one copy to Time Insurance Company and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

I hereby request and authorize you to furnish to Assurant Health or its representative any and all medical information concerning any illness or injury I may have suffered.

**X**  
Signature of Patient (If minor, parent must sign) \_\_\_\_\_ Date \_\_\_\_\_

If signed on behalf of another, indicate your relationship \_\_\_\_\_  
(Only if patient is unable to sign)

**PART TWO: EMPLOYER'S STATEMENT: TO BE COMPLETED BY EMPLOYER**

Employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Is disability due to an accident that occurred on the job?  Yes  No Dates unable to work due to accident/sickness: from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ Is he/she still employed?  Yes  No *If no, when did leave or layoff start, or employment terminate? \_\_\_/\_\_\_/\_\_\_*

Date employee is expected to return to work: \_\_\_/\_\_\_/\_\_\_ Job duties employee is unable to perform: \_\_\_\_\_

Signature of Employer \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_ Phone Number/Fax Number \_\_\_\_\_

**PART THREE: PHYSICIAN'S STATEMENT: TO BE COMPLETED BY PHYSICIAN**

<b>INSURED:</b>		<b>POLICY No.(s)</b>	
<b>ADDRESS:</b>		<b>CITY, STATE/ZIP</b>	
<b>PHONE No.:</b>		<b>BIRTHDATE</b>	____ - ____ - ____
		<b>SOCIAL SECURITY No.</b>	____ / ____ / ____

**HISTORY**

1. When did symptoms first appear or accident happen? \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Date patient stopped working because of disability? \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Has patient ever had same or similar condition?  Yes  No If yes, please describe: \_\_\_\_\_

**PRESENT CONDITION**

1. Subjective symptoms:  
\_\_\_\_\_
2. Objective findings (including results of current X-rays, EKGs or any other special tests):  
\_\_\_\_\_
3. Is patient  Ambulatory?  Bed-confined?  House-confined?  Hospital-confined?

**DIAGNOSIS** \_\_\_\_\_

**TREATMENT**

1. Date of first visit: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Frequency of visits:  Weekly  Monthly  Other
3. When did you last examine the patient? \_\_\_\_/\_\_\_\_/\_\_\_\_

**PROGRESS**  Full Recovery  Improved  Unimproved  Regressed

<b>EXTENT OF DISABILITY</b>	<b>FOR ANY OCCUPATION</b>	<b>FOR REGULAR OCCUPATION</b>
1. Is patient totally disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If no, when was patient able to go to work?	____/____/____	____/____/____
2. If yes, what date do you think patient will be able to resume work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone Number/Fax Number \_\_\_\_\_