Wage Protector® Program
Disability Initial Claim Form
Independent Contractor/Self-Employed
Everest Reinsurance Company c/o Allied National-Claims Administrator
PO Box 29186
Shawnee Mission, KS, 66201-9186

PLEASE READ BEFORE COMPLETING THIS DOCUMENT

- SUBMISSION OF AN INCOMPLETE OR UNSIGNED CLAIM FORM MAY RESULT IN A DELAY IN PROCESSING YOUR CLAIM.
- Insured must be disabled for 30 consecutive days prior to remitting a claim.
- The Insured's Statement is to be completed and signed by the insured.
- Insured should return completed Insured Statement and signed Release of Information Authorization to Everest Reinsurance Company c/o Allied National-Claim Administrator PO Box 29186, Shawnee Mission, KS, 66201-9186
- Attach your Last Year's Federal Income Tax Return
- Attach a copy of one of the following: Paystubs, Proof of Income Letter, Wage & Tax Statements (W-2, 1099's)

Policy No. _____

INSURED'S STATEMENT

1. Insured's Name _____

2. Address _____
   Street Address City State Zip

3. Phone Number _____ Date of Birth _____/_____/_____

4. First Date Worked _____/_____/_____ Last Date Worked _____/_____/_____ Date You Expect to Return to Work _____/_____/_____

5. Are you ☐ Self-Employed or ☐ an Independent Contractor? If you are self-employed, please enter the information about your business. If you are an independent contractor, please enter the information about your contracting employer(s).

6. Employment: If you are an independent contractor and have more than one contracting employer, please attach a separate sheet with information for each contract.

   a. Company Name _____ Supervisor's Name_____

   b. Address, Phone Number _____ Phone _____
      Street Address City State Zip

   c. Your Occupation _____ Specific Duties _____

   d. Employed from _____/_____/_____ through _____/_____/_____

7. Date accident occurred or sickness began _____/_____/_____ Date/time you stopped working: Date _____/_____/_____ Time _____AM / PM

8. If sickness, when were symptoms first noticed? _____

9. If injury, how and where did accident occur? _____

10. Was injury the result of a motor vehicle accident? YES / NO – If yes, please include copy of police accident report.

11. Please describe your sickness or injury. _____

12. When were you last troubled by this? _____

13. On what date were you FIRST treated by a physician either in their office or at a hospital after ceasing work? _____/_____/_____

14. Attending Doctor's Name _____ Address _____ Phone_____

15. Were you treated in the emergency room for this condition? YES NO – If yes, please include copy of admission form showing date admitted.

16. Were you hospitalized? Admission Date _____/_____/_____ Discharge Date _____/_____/_____

17. Please list all physicians who have treated you for this condition: (Please attach a separate page if additional space is needed.)
    Name City State Phone # Date Treated

    _____

    _____

18. Who is your primary physician? _____
    Name Street Address City State Phone #

For information or to check claim status, call 800-825-7531

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RELEASE OF INFORMATION AUTHORIZATION

I hereby request and authorize any contracting company, hospital (including Veterans Facility hospital), physician, or other person who has attended me or examined me, to furnish Everest Reinsurance Company c/o Allied National-Claims Administrator or its representative any and all information concerning any illness or injury I may have suffered, medical history, consultation, prescriptions, or treatments including X-ray plates and copies of all hospital or medical records, that same may be included as part of the proofs of loss submitted by me to the Company. A photocopy of this authorization shall be considered as effective and valid as the original. Everest Reinsurance Company c/o Allied National-Claims Administrator or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Insured's Signature _____ Dated _____/_____/_____

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- Attending Physician's Statement is to be completed by the Disabling Physician.
- Disabling Physician should return completed Attending Physician's Statement to Everest Reinsurance Company c/o Allied National Claims Administrator, PO Box 29186, Shawnee Mission, KS, 66201-9186

Policy No. _____

Patient's Name _____ Date of Birth _____/_____/_____

ATTENDING PHYSICIAN'S STATEMENT – DISABILITY CLAIM

NOTE TO PHYSICIAN

Since this insurance is designed to provide a benefit of monthly payments to the Insured based on the coverage they selected, please supply the information required on this form as soon as possible. Your prompt compliance will be greatly appreciated by both your patient and the company. The patient is responsible for completion of this form without expense to the company.

TO BE COMPLETED BY DISABLING PHYSICIAN

1. Diagnosis or Nature of Illness or Injury (include complications, if any) _____

   _____

2. When did symptoms first appear or accident occur? Date _____/_____/_____
3. When did patient first consult you for this condition? Date _____/_____/_____ Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____
4. Has patient ever had same or similar condition? Yes ☐ No ☐
5. Is this condition due to normal/routine pregnancy? Yes ☐ No ☐
6. Is this condition due to a scheduled C-section? Yes ☐ No ☐
7. If "Yes" to any of the above, describe & list all treatment dates during last twelve months (Please describe in space below or attach additional pages.) _____

   _____

   _____

8. Describe any other disease or infirmity affecting present condition or contributing to the disability: _____

   _____

9. Fully describe surgical procedure, if any _____

   _____

10. Date surgery was performed _____/_____/_____
11. Where was surgery performed? _____ If in hospital: In-Patient ☐ Out-Patient ☐
12. Was patient referred to you by another physician? _____
    Name Street Address

    _____
    City State Phone
13. When is patient expected to return to work? Date _____/_____/_____

Date Signature (Attending Physician) Degree Phone Number

Street Address City or Town State Zip Code

If you have any questions, please call Everest Reinsurance Company c/o Allied National-Claims Administrator at 800-825-7531.

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- SUBMISSION OF AN INCOMPLETE OR UNSIGNED CLAIM FORM MAY RESULT IN A DELAY IN PROCESSING CLAIM.
- Contracting Company's Statement is to be completed by each of the Insured's contracting company(s).
- The Contracting Company should return completed the Contracting Company's Statement to Everest Reinsurance Company c/o Allied National-Claims Administrator, PO Box 29186, Shawnee Mission, KS, 66201-9186.

Policy No._____ Insured's Name _____

CONTRACTING COMPANY'S STATEMENT

1. Start Date with your company_____/_____/_____
2. Last day worked _____/_____/_____ Date returned to work _____/_____/_____
3. Did the Insured work any period between these dates? Yes ☐ No ☐ If yes, please list dates _____
4. Occupation and specific duties _____
5. Full Time ☐ Part Time ☐ Is light duty available? Yes ☐ No ☐ Number of hours worked per week _____
6. Was the Insured a: Contractor Yes ☐ No ☐
   Self-Employed Yes ☐ No ☐
   Seasonal Worker Yes ☐ No ☐
7. Is the present condition the result of an accident or injury on the job? Yes ☐ No ☐
8. If yes, please give a date of accident or injury. _____/_____/_____
9. If yes, please include a copy of the worker's compensation claim report filed, if applicable

Date	Signature (Contracting Company or Supervisor)	Contracting Company	Phone Number

Street Address	City or Town	State	Zip Code

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