Wage Protector® Program
Disability Initial Claim Form
Employee
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 - Claims Administrator, PO Box 29186, Shawnee Mission, KS 66021-9186.

Policy No. _____

INSURED'S STATEMENT

1. Insured's Name _____
2. Address _____
   Street Address City State Zip
3. Phone Number _____ Date of Birth _____/_____/_____
4. Employment:
   a. First Date Worked _____/_____/_____ Last Date Worked _____/_____/_____ Date You Expect to Return to Work _____/_____/_____
   b. Employer Name _____ Supervisor's Name_____
   c. Employer's address _____ Employer's phone _____
      Street Address City State Zip
   d. Your Occupation _____ Specific Duties_____
   e. Employed from _____/_____/_____ through _____/_____/_____
   f. If you changed employers since the policy was issued, provide name, address and phone number of prior employer _____
5. Date accident occurred or sickness began _____/_____/_____ Date/time you stopped working: Date _____/_____/_____ Time _____AM / PM
6. If sickness, when were symptoms first noticed? _____
7. If injury, how and where did accident occur? _____
8. Was injury the result of a motor vehicle accident? YES / NO – If yes, please include copy of police accident report.
9. Please describe your sickness or injury? _____
10. When were you last troubled by this? _____
11. On what date were you FIRST treated by a physician either in their office or at a hospital after ceasing work? _____/_____/_____
12. Attending Doctor's Name _____ Address _____ Phone_____
13. Were you treated in the emergency room for this condition? YES NO – If yes, please include copy of admission form showing date admitted.
14. Were you hospitalized? Admission Date _____/_____/_____ Discharge Date _____/_____/_____
15. 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
    _____
    _____
16. Who is your family 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 employer, 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 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 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 _____/_____/_____