WAGE PROTECTOR® Program
Disability Initial Claim Form
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 CLAIM.
- 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.