North American Benefits Company
20 Valley Stream Parkway, Suite 310
Malvern, PA 19355

EMPLOYEE'S STATEMENT

(Employee must complete promptly and send to Attending Physician)

Employee's name _____ ☐ M ☐ F Date of birth _____, ____

Home address _____
Street and Number City State Zip Code

Description of injury or sickness _____

Date first symptoms of sickness appeared _____, ____

Is inability to work due to accident? ☐ Yes ☐ No If Yes, include the following information:

Date of accident _____, ____ Details of accident _____

Were you confined to a hospital? ☐ Yes ☐ No If Yes, give name and address of hospital

Date Entered Date Discharged

_____ _____ _____

Did this sickness or injury arise from your employment? ☐ Yes ☐ No

First date you were unable to work due to this injury or sickness _____, ____

Have you returned to work since that date? ☐ Yes ☐ No

If Yes, give:

Date returned to work _____, ____ OR, dates worked _____

Date _____ ____ _____ _____
Employee Soc. Sec. No. Employee's Signature

Have you ever applied for benefits under this policy prior to this application? ☐ Yes ☐ No

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I authorize any physician, hospital, clinic, dispensary, sanatorium, druggist, insurer, or employer having any records, data or information concerning my medical history, mental or physical condition or treatment, prescriptions and employment, to furnish such records, data or information as may be requested to North American Benefits Company. A photocopy of this authorization shall be considered as effective and valid as the original.

The records are requested for insurance claims purposes. The individual signing below may receive a copy of this authorization form. This authorization is valid for the duration of the insurance claim.

Dated _____, ____ Signed _____

Address _____
(Street and Number) (City) (State) (Zip Code)

Phone Number (include area code) _____

PLEASE TYPE OR PRINT

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name _____ Age _____

1. Diagnosis (Describe complications, if any) _____

Patient's Disability is a result of ☐ Sickness ☐ Injury

2. Did this sickness or injury arise out of patient's employment? ☐ Yes ☐ No

If Yes, explain _____

_____

3. Is disability due to normal pregnancy? ☐ Yes ☐ No Complications of pregnancy? ☐ Yes ☐ No

If complication, describe _____

If Yes, what is approximate date of delivery? _____
MONTH DAY

If delivered, give date of delivery. _____ Cesarean Section? ☐ Yes ☐ No
MONTH DAY

4. First date of treatment: _____

Describe treatment and list dates of treatment: _____

_____

_____

_____

Hospital Admissions:

_____
Hospital Name Dates

_____
Hospital Name Dates

_____
Hospital Name Dates

5. The patient has been continuously disabled (unable to work) from _____ through _____
MONTH DAY MONTH DAY

6. If still disabled, when should patient be able to return to work? _____ (Please estimate)
MONTH DAY

Prognosis: _____

Remarks: _____

_____

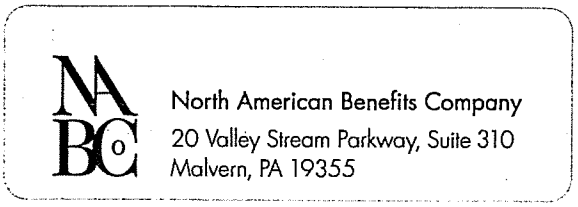
Date _____ _____ M.D.
Signature of Attending Physician

_____
Print or Type Name of Attending Physician

Phone ( ) _____

_____
PRINT (Street Address) (City or Town) (State) (Zip Code)

TO THE ATTENDING PHYSICIAN: After completing the above, please send this form directly to the address below. The employee is responsible for the completion of this form without expense to the Company.



AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I authorize any medical professional, hospital or other medical-care institute, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide the insurance carrier for this coverage or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the patient, Insured Person or deceased name below, as well as information relating to death of such person, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide such insurance carrier or its authorized representative with any financial or employment-related information that may be pertinent to the claim. I understand that such information will be used for the purpose of evaluating my claim for insurance benefits and that I, or an authorized representative, will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of coverage under the policy.

_____ _____

Signature of Patient Signature of Insured

_____

Date Signed

NABCo
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