Chartis Insurance **PROOF OF LOSS**

A&H Claims Department
P. O. Box 828
Annandale, VA 22003-0828
800-221-3083 x 209 Fax 703-642-2240

NAME OF GROUP:

POLICY NUMBER:

DISABILITY INDEMNITY SUPPLEMENTAL REPORT

INSTRUCTIONS:
1.) Section A must be completed in full by claimant.
2.) Section B must be completed in full by Attending Physician.
3.) This form must be signed and dated in all applicable sections.
4.) This form must be submitted to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A- CLAIMANT'S STATEMENT (Please Print or Type)

Claimant's Full Name ____Telephone Number ( ) -
First Middle Last

Address____
Number Street City or Town State Zip Code Apt #

On what date(s) since the last statement furnished by you were you treated by a physician?____________________

Names and addresses of current attending physicians:

Physician's Name:____

Office Address: _________________
Number Street City State Zip Code

Physician's Name:____

Office Address:____
Number Street City State Zip Code

Have you returned to work?______If yes, on what date?______________________________

If not, when do you expect to return?____

For what period were you continuously disabled? From_____________________Through_____________________

Have you retired from your business or occupation?_______ If yes, when?_________________________________

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

SIGNATURE: DATE:

SECTION B- ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Claimant's Name:____

Please answer all questions

1. Nature of sickness or injury and complications, if any, causing disability?______________________

____

____

____

2. What operations, if any, were performed since last statement?______________________

3. Give all dates of treatment since last statement: Home______________Office______________

4. Was claimant hospitalized since last statement? ________From____________To______________

   Name and Address of Hospital:______________________________________

5. Have any other physicians been in attendance or consultation since last statement?______________

   If yes, give their names and addresses:______________________________

____

____

6. Current limitations and restrictions, if any:______________________________

____

7. Is this claimant totally disabled from each and every occupation?______________________

   If no, please explain:______________________________________

____

____

8. (a) How long was or will claimant be totally disabled from current occupation? From_______To______________

   (b) How long was or will claimant be partially disabled from current occupation? From_____To______________

   (c) Estimated return to work date:______________________________

9. What is the prognosis?______________________________________

____

Doctor's Signature______________________________________Date____________________

Doctor's Name (please print or type)____________________________Tel.#(   )________________

Office Address____

Number Street City or Town State Zip Code