



INSTRUCTIONS: (1) Complete the Statement of Insured below. Have patient's physician complete Part 3 on the reverse side. (2) Return form and attachments to the address above; or as instructed by your employer.

PART 1. - TO BE COMPLETED BY THE EMPLOYEE

Personal Data	1. Name of Employee _____		Social Security # _____		Name of Employer _____		
	2. Address _____		Number of Street _____		City and State _____		ZIP Code _____
					Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____ <input type="checkbox"/> Married <input type="checkbox"/> Single
3. Explain the nature of the sickness or injury _____				A. Was the sickness or injury due to the person's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Insurance	4. Are you eligible to receive payment for this claim under any other insurance plan provided by any other group service or Government plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", answer below.						
	5. A. Name of organization making payments _____			B. Address _____		C. Amount Paid _____	
	6. A. Name of person carrying other coverage _____			B. Policy Number & Certificate Number _____		C. Date of Birth _____	
Accident Information	7. Is this claim due to an accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			A. Was the accident due to the injured person's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	B. Where was injured person when accident occurred? _____				C. Date of Accident _____		Hour _____ A.M. P.M.
	D. What was injured person doing when accident occurred? _____				E. How did accident occur? _____		
Authorization	8. Have you engaged in any occupation or business since the beginning of this disability? If so, give particulars. _____						
	9. On what date were you first treated by a physician for this disability? _____						
	10. Physician(s) whom you consulted during present illness? _____						
	Name _____		Address _____		Period Treated		
	_____		_____		From _____ To _____ From _____ To _____		
I hereby certify that the foregoing statements, including any accompanying statements, are true and complete to the best of my knowledge. I hereby Authorize any physician, hospital, insurance company, organization or employer to release any information including full copies of their records to AMERICAN NATIONAL INSURANCE COMPANY for any medical treatment, services or benefits rendered payable to me (or my dependents). A photostat of this authorization shall be as valid as the original.							
Date _____ Signature of Insured _____							

PART 2. - TO BE COMPLETED BY THE EMPLOYER

Employer Data	1. Job Title of Employee _____		Effective Date _____		Group Policy No. _____		Unit No. _____
	2. Is insurance still in force? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not give date of termination _____				
	3. Did injury or illness for which claim is being made arise out of, or in the course of, any occupation or employment for wages or profit? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	4. Has claim been made under one of the following? <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Employer's Liability <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate which one.						
Work Status	5. Has the injury or illness resulted in absence from work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete the following"						
	A. Date last worked _____		_____ at _____		o'clock _____		A.M. P.M.
	B. When did he return to work? _____		_____ at _____		o'clock _____		A.M. P.M.
	C. If not back at work, when do you expect him to return? _____ D. Base Salary _____ Per: _____						
Authorized Signature	Dated _____				Employer _____		
	Address _____				By _____		

PLEASE PRINT
Name of Patient

Age Policy Number

Present No. Street City State (or Province) ZIP Code
Address

If Group Insurance give name of Policyholder
(i.e., Employer, Union or Association Through Whom Insured)

Insured's Name if Patient is a Dependent

ATTENDING PHYSICIAN'S STATEMENT OR DISABILITY
THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

1. HISTORY

- (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ YR _____
- (b) Date patient ceased work Mo. _____ Day _____ YR _____
- (c) Has patient ever had same or similar condition? Yes No
If "Yes", state when and describe.
- (d) Is condition due to injury or sickness arising out of patient's employment? Yes No If "Yes", Explain
- (e) When did patient first consult you for this condition?
- (f) Was this patient referred to you by another physician? If "Yes", please give name and address of referring physician.

2. PRESENT CONDITION

- (a) Subjective symptoms
- (b) Objective findings
Include results of current X-Rays, E.K.G.s or any other special tests.
- (c) Is patient: Ambulatory? Confined to Bed? Confined to House? Confined to Hospital?

3. DIAGNOSIS

4. TREATMENT

- (a) Date of first visit? Mo. _____ Day _____ YR _____
Date of last visit? Mo. _____ Day _____ YR _____
Frequency of visits Weekly Monthly Other
- (b) When did you last examine the patient? Mo. _____ Day _____ YR _____

5. PROGRESS

Recovered Improved Unimproved Retrogressed

6. EXTENT OF DISABILITY

- (a) Is patient now totally disabled? Yes No FOR ANY OCCUPATION FOR HIS REGULAR OCCUPATION Yes No
- (b) If no, when was patient able to go to work? Mo. _____ Day _____ YR _____ Mo. _____ Day _____ YR _____
- (c) If "Yes", when do you think patient will be able to resume any work? Approximate Date _____ Mo. _____ Day _____ YR _____
Indefinite _____
Never _____
- (d) If "Yes", is patient a suitable candidate for a rehabilitation program? Yes No

7. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes No

Complete appropriate section if disability is due to CARDIAC CONDITION.

8. CARDIAC

- (a) Functional capacity (American Heart Assn.) _____ Class 1 (No limitation) Class 2 (Slight Limitation)
Class 3 (Marked Limitation) Class 4 (Complete Limitation)
- (b) Blood pressure _____

REMARKS:

Date Signature (Attending Physician) Degree Telephone

Street Address City or Town State or Province ZIP Code