



PO Box 80926
Lincoln, NE 68501

Application for Individual Benefits

Your claim will be reviewed within 15 business days.
You will receive notification in writing.

Toll Free 866-289-7337
Fax 402-437-4592

1. Name of Policyowner _____
 Last First Middle
 Policy Number(s) _____
 Social Security Number _____
 Phone Number _____
2. Name of Patient (if different from policyowner) _____
3. Business or occupation _____
4. Employer's name _____
 Employer's address _____
 Street City State Zip Code
5. When did the physician first treat you? _____
 Give other dates of treatment _____
6. Name of treating physician(s) _____
 Physician(s) address and phone _____
7. Full name of your primary care physician _____
 Address and phone number _____
8. If accident, when did it happen? _____, 200 ____ . Time of day _____
 How and where did accident happen? _____
9. If sickness, when did it begin? _____ Nature of illness _____
 Have you ever had this same illness before? Yes No When? _____
10. Are you or will you be applying for benefits under any State or Federal Worker's Compensation law? Yes No
11. Were you confined to a hospital? Yes No Was an operation performed? Yes No
 If yes, describe _____
 Date & Time entered _____ Date & Time discharged _____
 Name of hospital _____
 Address & phone of hospital _____

If you are applying for **DISABILITY BENEFITS**, please complete:

12. On what date did you stop performing all of your employment duties? _____
13. When did or do you expect to return to some of your employment duties? _____
14. When did or do you expect to return to all of your employment duties? _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

I hereby agree to reimburse Assurity to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(cies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

Signature of Policyowner _____ Date _____

DISABILITY BENEFITS ARE SUBJECT TO PERIODIC REVIEW

Mail claim form to address listed above
Make copies for your records

EMPLOYER'S STATEMENT: Must be completed **BY EMPLOYER** for disability benefits.

1. Date of first absence due to disability _____ Date employee returned to work _____
 2. Monthly earnings _____ Date hired _____ Date of termination/retirement if applicable _____
 3. Has claim or will claim be made for Worker's Compensation Benefits? Yes No
If yes, what is status of claim? _____
 4. Will you provide "light duty" if employee is released with restrictions? Yes No
 5. Are policy premiums paid on a pre-tax basis? (i.e., cafeteria, flex plan, Section 125) Yes No
- Name of Employer _____ Phone number of employer (____) _____ - _____
 Authorized Signature _____ Fax Number of employer (____) _____ - _____
 Print Name _____ Title or Position _____ Date _____

NAME OF PATIENT (PRINT)		DATE OF BIRTH	POLICY NO.	
PRESENT ADDRESS	STREET	CITY	STATE	ZIP CODE
<input type="checkbox"/> Check here if new address				

Attending Physician's Statement**(Must be completed and signed by physician for disability benefits)**

* = Required Field

1. *Diagnosis and concurrent conditions (If diagnosis code other than ICDA* used, give name):

2. *Report of services (If previous form submitted to this carrier, you need to show only dates and services since last report.)

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SERVICE	PROCEDURE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. *Date symptoms first appeared or accident happened. _____	4. *Date patient first consulted you for this condition. _____
6. *Patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" when and describe:	6. Patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. *Patient was continuously totally disabled (unable to work) FROM _____ THRU _____	8. *Patient was partially disabled FROM _____ THRU _____
9. If still disabled, date patient should be able to return to work.	10. If disability is due to pregnancy, note expected delivery date OR date of birth, and vaginal or C-section delivery.
11. Patient entered hospital DATE _____ TIME _____	12. Patient discharged from hospital DATE _____ TIME _____

*Date	Physician's Name (Print)	Signature	Degree	Telephone
*Street Address		City or town	State	ZIP Code Fax