

S.S. No. _____
 Claim No. _____
 Policy No. _____
 Ctf. No. _____

**APPLICATION TO
 THE UNION LABOR LIFE INSURANCE COMPANY
 FOR TOTAL AND PERMANENT DISABILITY BENEFITS**

**STATEMENT OF
 CLAIMANT**

If Claimant is mentally incompetent, the Statement may be completed by the Guardian or Committee, or if none has been appointed, by the Beneficiary named in the Policy.

1. What is your full name? _____ Date of Birth? _____
2. Address? _____ Occupation? _____
3. Name and address of last employer? _____ SS# _____
4. Nature of present sickness or injury? _____
5. On what date were you first totally disabled by this sickness or injury? _____
6. On what date did you stop work? _____
7. Have you engaged in any occupation or business since the beginning of this disability? If so, give particulars _____
8. On what date were you first treated by a physician for this disability? _____

9. Physicians whom you consulted during present illness:

Name	Address	Period Treated
Dr. _____	_____	From _____ to _____
Dr. _____	_____	From _____ to _____
Dr. _____	_____	From _____ to _____

10. Hospitals and dispensaries where you were treated during present illness:

Name	Address	Period Treated
_____	_____	From _____ to _____
_____	_____	From _____ to _____

11. What other insurance have you (accident, sickness, disability or life)?

Name of Company, Society or Lodge	Address	Disability Benefits	Amt. of Ins.
_____	_____	\$ _____ per _____	\$ _____
_____	_____	\$ _____ per _____	\$ _____
_____	_____	\$ _____ per _____	\$ _____

12. Have you been retired by the City, State, Federal Government or other employer for disability? If so, give date _____

Date _____, _____ Signature of Insured or Representative _____

We certify that the above claimant was eligible for the insurance at the commencement of disability, that his insurance will terminate on _____, and that we believe his claim to be submitted in good faith.

Benefit Amount _____ Name of Policyholder _____

Date _____, _____ (OVER) By _____

(PRINT) Name of Patient		AGE	POLICY NUMBER
Present Address	NO. STREET CITY	STATE (OR PROVINCE)	ZIP CODE
IF GROUP INSURANCE GIVE NAME OF POLICYHOLDER (I.E., EMPLOYER, UNION OR ASSOCIATION THROUGH WHOM INSURED)		INSURED'S NAME IF PATIENT IS A DEPENDENT	

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

1. HISTORY

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____

(b) Date patient ceased work because of disability. Mo. _____ Day _____

(c) Has patient ever had same or similar condition? Yes No
If yes, state when and describe.

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? Bed confined? House confined? Hospital confined?

3. DIAGNOSIS

4. TREATMENT

(a) Date of first visit Mo. _____ Day _____
Date of last visit Mo. _____ Day _____
Frequency of visits Weekly Monthly Other

(b) When did you last examine the patient? Mo. _____ Day _____

5. PROGRESS Recovered Improved Unimproved Retrogressed

6. EXTENT OF DISABILITY

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

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** or **VISUAL IMPAIRMENT**.

8. CARDIAC

(a) Functional capacity (American Heart Ass'n) ...	Class 1 (No limitation) <input type="checkbox"/>	Class 2 (Slight limitation) <input type="checkbox"/>
	Class 3 (Marked limitation) <input type="checkbox"/>	Class 4 (Complete limitation) <input type="checkbox"/>
(b) Blood pressure		

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE (OR PROVINCE)	ZIP CODE