

EMPLOYER'S STATEMENT OF CLAIM FOR:

- WAIVER OF PREMIUM DISABILITY
- DISMEMBERMENT



By furnishing this form and investigating the claim the Company shall not be held to admit validity of any claim or to waive the breach of any condition of the policy. The Company reserves the right to require and obtain such additional statements and information as it deems necessary.

The laws of some states require us to furnish you with the following notice: It is unlawful to knowingly file a claim statement that provides materially false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. The company is required to report suspected fraudulent activity to the Department of Insurance or appropriate regulatory authorities.

INSTRUCTIONS

1. Notice of disability or dismemberment claim is to be filed only if the group policy provides such coverage.
2. Complete the form and send to United Heritage Life Insurance Company, P.O. Box 7777, Meridian, Idaho 83680-7777.
3. Our Claims Department will then send forms to be completed by the disabled person and his/her physician.

1. Employer		2. Employer Telephone # () area code		3. Group Policy Number	
4. Employee's Name		5. Social Security #	6. Sex	7. Date of Birth	
8. Residence (Street, City, State, Zip Code)		9. Date Employed		10. Occupation	
11. Effective Date of Insurance		12. Was Insurance Terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give Date and Reason			
13. How many hours per week did the employee work immediately prior to total disability or dismemberment?					
14. How many weeks did the employee work in the 52 weeks immediately prior to total disability or dismemberment?					
15. Was he/she considered an employee on date of disability or dismemberment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain				16. Amount of Insurance \$	
17. If not still actively at work, give date last worked full time		18. Date of disability or dismemberment		19. Wage or Salary \$ Per _____	
20. Reason for leaving work: <input type="checkbox"/> Disability (Including Disability Leave of Absence) <input type="checkbox"/> Leave of Absence (Other than Disability) <input type="checkbox"/> Quit <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Vacation <input type="checkbox"/> Temporary Layoff <input type="checkbox"/> Other _____					
21. Nature of disease or injury causing disability					
22. Attending Physician Name and Address					
23. Was disability or dismemberment due to an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO if Yes, a. Was it due to an injury arising out of and during the course of employment? _____ b. What was employee doing when the injury occurred? _____ c. Describe how the injury occurred _____					
24. Does this employee have dependent life insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. The employee is receiving or has applied for: <input type="checkbox"/> WORKER'S COMPENSATION BENEFITS <input type="checkbox"/> SICK PAY <input type="checkbox"/> UNEMPLOYMENT COMPENSATION DISABILITY <input type="checkbox"/> SALARY CONTINUANCE BENEFITS					

We believe that this employee was eligible and insured under the provisions of the group policy and as indicated by the information shown above.

Employer _____

By _____

Title _____ Date _____