Cherokee National Life Insurance Company

P.O. Box 6097 Macon, Georgia 31208-6097
1-800-849-4265

Send completed form to:
Evans, Simpson & Associates
P.O. Box 1549
Snellville, GA 30078-1549

CREDIT UNION CLAIM FORM

FIRST CLAIM REPORT

Physician's Statement and Instructions for completion on reverse side

CREDITOR'S

Part 1 Creditor's Statement

First Beneficiary-Creditor _____ Phone _____
Address _____ By _____
Date _____
City State Zip Code
Comments _____ **Date of Death** _____

Loan #	Original Loan Date	Loan Balance on Date of Disability	Monthly Payment Amount

List any money advanced & payment changes in 6 mos. prior to date of disability.

(Date) / (Amount) / (Payment)	(Date) / (Amount) / (Payment)	(Date) / (Amount) / (Payment)	(Date) / (Amount) / (Payment)
Ex: 4-15-08 / 500 / 150			

EMPLOYER'S

Part 2 Employer's Statement

Date last worked:		Date returned and performed any part of his duties after illness or injury:	
Is this illness or injury covered by workmen's compensation? Yes ☐ No ☐		If "Yes", give name, address and phone # of carrier	Date of Accident
When recovered, will he resume work with you? Yes ☐ No ☐		If "No", why?	
Job Title	Average hours per week?	Employee's regular duties are:	and require: (check ones applicable) Heavy Lifting ☐ Long Time Standing ☐ Work Seated ☐ Stooping or Bending ☐

Employer's Name	Signature of Company Representative Furnishing This Information	
Address	Phone	Date

INSURED'S

Part 3 Insured's Statement

Full Name	Age	Date of Birth	Social Security #

Number and Street Address	City	State	Zip Code	Home Phone #

What date did you last work?	What kind of sickness or injury?
If sickness, when were the first symptoms noticed?	If injured, how and where did the accident occur?

Name, address and phone # of doctors treating you for sickness or injury:

Name, address and phone # of doctors treating you in past two years. Indicate date and illness or injury:

Are you now receiving, or have you applied for benefits such as social security, unemployment, or other disability benefits?
Yes ☐ No ☐ If yes, explain and give dates:

Medical and Employment Information Authorization

I certify that the above statements are true and correct to the best of my knowledge. I understand that any benefits will be paid to my creditor (as indicated above) t be applied to my account, with any excess to be paid to me, the named second beneficiary or my estate.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, Medical Information Bureau, insurance company, consumer reporting agency, rehabilitative assessment agency, government authority, or any past or present employer, to furnish Cherokee National Life Insurance Company, its reinsurers, or their representatives, any information related to my health, medical history, diagnosis, treatment, including alcohol or drug abuse information, and non-medical information relative to my financial condition, MY COMPENSATION AND EMPLOYMENT STATUS or credit activity for the purpose of evaluating my claim for insurance benefits. I further authorize Cherokee National Life Insurance Company to disclose any such information to any insurance company to whom I may apply for life and health insurance for the purpose of determining my insurability or to whom a claim for benefits may be submitted for the purpose of processing such claim. I understand I have the right to receive a copy of this authorization. This authorization shall remain valid for the pendency of the claim or the term of the coverage.

Date _____ Insured Debtor's Signature _____

Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may subject such person to criminal prosecution and civil penalties.

Part 4 — Physician's Statement

To Be Furnished Without Expense To The Company

1. Patient's Full Name _____ Sickness ☐ Accident ☐ If Accident, Date:

2. Diagnosis and concurrent conditions (Describe complication, if any)	
3. When did patient first consult you for this condition?	Date
4. Has patient ever had similar condition (if "yes" state when and describe)	☐ Yes ☐ No Date: Condition:
5. Names of physicians who previously treated patient for the above condition	
6. Have you referred patient to another physician? If "yes" name and address of physician(s)	☐ Yes ☐ No Name: Address:
7. Is condition due to pregnancy? If "yes", approximate commencement date.	☐ Yes ☐ No Date:
8. Give dates of treatment	Office: Hospital:
9. If hospitalized, give dates, name and address of hospital.	From: To: Name: Address:
10. Is patient still under your care for this condition? If "no", give date your service terminated.	☐ Yes ☐ No Date:
11. When was patient first unable to work because of this condition?	Date:
12. How long will patient be totally disabled (unable to work)? **Must have beginning date of disability.**	From: To: ☐ His/Her Occupation ☐ Any Occupation
13. How long will patient be partially disabled?	From: To: ☐ His/Her Occupation ☐ Any Occupation
14. Are you the family physician? For what have you previously treated the patient?	☐ Yes ☐ No Dates previously treated:

15. Physical Impairment ("as defined in Federal dictionary of Occupational Titles)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions (0-10%)
- ☐ Class 2 - Medium manual activity (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work (33-35%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)

16. Prognosis

Date	Physician's Name (Print)	Degree	
Physician's Signature	Phone	Specialty	
Street Address	City or Town	State	Zip

ALL QUESTIONS IN EACH PART MUST BE ANSWERED OR DELAY MAY RESULT IN PAYMENT OF CLAIM

Instructions for completion of Proof of Loss:

Notice: To ensure monthly payments, a claim should be filed every 30 days.

Part 1: To be completed by the Credit Union representative

Part 2: To be completed by the Insured's employer

Part 3: To be completed by the Insured. Be sure to sign and date.

Part 4: To be completed by the Insured's treating physician. This is to be furnished without expense to Cherokee National Life Insurance Company.

PHYSICIAN'S