

Claimant's Supplementary Statement

(For Continuing Disability Only)

Liberty Life Insurance Co. PO Box 19038 Greenville, SC 29602-9038

Monday-Friday 8:30-5:00 EST
(800) 551-8354

This form is to be completed to provide proof of continued disability on the following type coverage:

(Check one) Disability Income Premium Waiver

Policy Number(s):

Home Office Use Only

1. Insured's name: _____ Date of birth: _____

2. Address: _____

3. Describe the cause of current disability: _____

4. List any physicians and medical treatment provided to you since your last report:

Name _____ Treatment _____

Name _____ Treatment _____

5. List any medications you are now taking: _____

6. Describe your regular job duties at the time you became disabled: _____

7. Describe your current condition and activities (*List limitations*):

NOTICE

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, hospital, clinic, physician, surgeon, employer or practitioner to furnish to Liberty Life Insurance Company, Greenville, South Carolina, or its representative, any and all information concerning any illness or injury I may have suffered and copies of all hospital or medical records, so the same may be included as part of the claim submitted to the Company. A reproduced copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Insured _____

Phone No. _____ Social Security No. _____