1015 – 30R/25 HRS DISABILITY BENEFIT ACTIVATION 30 R

IMPORTANT: DO NOT COMPLETE ANY OF THIS FORM UNTIL YOU HAVE BEEN TOTALLY DISABLED FOR 30 DAYS. IF THIS FORM IS COMPLETED PRIOR TO THE 30 DAY WAITING PERIOD, WE WILL NOT BE ABLE TO ACCEPT IT.

FILL OUT PART ONE, BE SURE TO COMPLETE FIELDS #1 THROUGH #26 b

PRINT THE FORM AFTER COMPLETING THE ABOVE INDICATED FIELDS

SIGN AND DATE THE BOTTOM OF PAGE ONE

PAGE TWO NEEDS TO BE COMPLETED BY YOUR PHYSICIAN

PAGE THREE NEEDS TO BE COMPLETED BY YOUR EMPLOYER

RETURN ALL THREE COMPLETED PAGES TO:

PEKIN LIFE INSURANCE COMPANY
ATTN: FINANCIAL PRODUCTS BENEFITS DEPT.
2505 COURT STREET
PEKIN IL 61558

309-346-1161, x 2329

Disability 30 Day Retro
Benefits Activation Form

FINANCIAL INSTITUTION – COMPLETE THIS SECTION BEFORE GIVING FORM TO PROTECTED BORROWER

Name of Insured in full ____________________

Customer ID number____________________ Term of Loan ____________________ Loan Date ____________

Creditor ____________________ Agent #____________

Completed by ____________ Title ____________ Date ____________ Phone____________

Benefits Activation Form must be signed and dated by the attending physician 30 days or more after the start of the disability. Protected Borrower Disability Authorization Form must be signed and dated by the Protected Borrower 30 days or more after the start of the disability.

Please complete all fields. Missing information may cause processing delays.

Part 1 – To be completed by Protected Borrower

1. Customer ID Number	2. Last 4 Digits of Social Security Number	3. Date of Birth
4. Last Name	5. First Name	6. Middle Initial
7. Address	8. City	8a. State / 8b. Zip
9. Phone Number	10. Has your loan been refinanced? ❑ Yes ❑ No If yes, please provide prior loan number.	
11. Date of Disability Beginning (mo-day-yr) End (mo-day-yr)	12. Is disability due to injury? ❑ Yes ❑ No If yes, please provide date of injury (mo-day-yr)	
13. Condition causing disability?	14. Date you were first treated for your illness or injury (mo-day-yr)	
15. Date Hospitalized: ____________ to ____________	16. Name & Phone Number of Hospital ____________________	
17. Attending Physician's Name	18. Attending Physician's Phone Number (Required)	
19. Attending Physician's Fax Number (Required)	20. Attending Physician's Street Address	20a. City / 20b. State / 20c. Zip
21a. After becoming disabled, have you worked for wages or profit in your occupation? ❑ Yes ❑ No If yes, please see 21b and 21c. 21b. Please provide start date (mo-day-yr) and end date (mo-day-yr). ____________________ 21c. Are you still working? ❑ Yes ❑ No		
22. Primary Physician Name (if different from #17)	23. Phone Number (Required)	24. Fax Number (Required)
25. Street Address	26. City	26a. State / 26b. Zip

I hereby certify that the answers given above are full and true.

____________________________________ ____________________

Signature **Date**

Return completed forms to:
Pekin Life Insurance Company, Financial Products Benefit Activation, 2505 Court Street, Pekin, IL 61558.

CL 1015-30R/25HRS (11-07)

Disability 30 Day Retro Benefits Activation Form – Page 2

Please complete all fields. Missing information may cause processing delays.

Part 2 – To be completed by Physician **Patient Name:** ______________________

27. Diagnosis and Concurrent Condition

28. Has this patient been treated for this condition before?
❑ Yes ❑ No If yes, please include dates. (mo-day-yr)

29. Since the start date of disability is this patient under your continuous care? ❑ Yes ❑ No

30. Date this patient was unable to perform the principal duties of the occupation held when he/she became disabled. (mo-day-yr)

31. Was patient hospitalized
❑ Yes ❑ No

32. Name and address of Hospital

33. Hospital admission date (mo-day-yr)

34. Hospital release date (mo-day-yr)

35. If applicable, return to work date (mo-day-yr)

36. Was surgery performed on this patient? ❑ Yes ❑ No

37. Is disability due to: (please mark one)
❑ Sickness
❑ Injury, please specify date of injury (mo-day-yr). Please see 38.
❑ Work related injury, please specify date of injury (mo-day-yr). Please see 38.
❑ Pregnancy – Was pregnancy normal? ❑ Yes ❑ No (If no, please list complications)

38. If disability was due to an injury, was that injury self-inflicted, due to a commission of an assault or felony, foreign travel, or flight in non-scheduled aircraft? ❑ Yes ❑ No

39. In your expert opinion, how would you qualify this patient – please mark one:
❑ Permanently Disabled ❑ Temporarily Disabled ❑ Non-Disabled

40. Was this patient referred to you by another Physician?
❑ Yes ❑ No

41. If yes, please provide Physician's name.

42. Referring Physician's Street Address

43. City

43a. State

43b. Zip

44. Please provide complete name and address of any other treating Physician(s) or Hospital(s). If extra space is needed, please submit on a separate sheet of paper.

45. Attending Physician's Printed Name

46. Street Address

46a. City

46b. State

46c. Zip

47. Phone Number (Required)

48. Fax Number (Required)

49. Attending Physician's Signature

50. Date

Return completed forms to:
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Disability 30 Day Retro Benefits Activation Form – Page 3

<u>Part 3 – To be completed by Employer</u> – If self employed, please provide copy of business license, in addition to completing Part 3. **Employee Name:** ______________________________

51. Company Name			52. Company Address		
53. City			53a.State	53b. Zip	54. Hire Date (mo-day-yr)
55. Last date of work before employee became disabled (mo-day-yr)			56. Date employee became disabled (mo-day-yr)		
57. If the last date of work and the date the employee became disabled are not consecutive, please explain.					
58. Employee return to work date, if applicable (mo-day-yr)			59. Employee paid through date (mo-day-yr)		
60. Did employee work at least 25 hours per week for the 30 days prior to start date of disability? ❑ Yes ❑ No If no, please complete 60a.					
60a. Reason for not working 25 hours per week for the 30 days prior to start date of disability: ❑ Sick/Vacation, list days ______________________ ❑ Part time Employment ❑ Other, please specify					
61. Employee's Occupation and Job Duties					
62. Employer/Manager Full Name	63. Employer/Manager Title			64. Phone Number (Required)	
65. Fax Number (Required)	66. Signature				67. Date

Return completed forms to:
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