CareAmerica
Life Insurance Company

P.O. Box 7725, San Francisco, CA 94120
1-888-646-0789

WAIVER OF PREMIUM CLAIM FORM FOR CAREAMERICA LIFE INSURANCE COMPANY (CAREAMERICA LIFE)

NOTE: Please complete the entire claim form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

STATEMENT OF APPLICANT

FULL NAME				TELEPHONE NO. ( )
ADDRESS (NUMBER, STREET, APARTMENT)		CITY	STATE	ZIP
BIRTHDATE (mo/day/yr)	SOCIAL SECURITY NO.	SEX ☐ Male ☐ Female	DATE HIRED	LAST DAY AT WORK

Date you became unable to work at your occupation as a result of illness or injury:

Did disability result from employment? ☐ Yes ☐ No

Have you been CONTINUOUSLY disabled since you became unable to work? ☐ Yes ☐ No

If YES, when CAN you resume your duties at work?

If NO, when DID you become able to work?

Is your disability due to an ☐ ACCIDENT ☐ ILLNESS? If an accident, describe the incident (including date and place). If an illness, identify when the symptoms first appeared: (Attach explanation if more space needed)

_____

_____

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I hereby authorize any hospital or physician who has attended to me to disclose when requested to do so by the CareAmerica Life Insurance Company any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed: **X** _____ DATED _____, 20_____

IMPORTANT NOTICE: For your protection, California law requires the following to appear in this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

STATEMENT OF GROUP POLICYHOLDER (Employer)

EMPLOYER'S NAME			
GROUP POLICY NO.	EFFECTIVE DATE OF POLICY	TELEPHONE NO. ( )	
DATE OF HIRE	JOB TITLE		
Was employee actively at work the day before disability? ☐ Yes ☐ No	LAST DATE PREMIUM PAID	LAST DAY OF WORK BEFORE DISABILITY COMMENCED	NUMBER OF HOURS WORKED PER WEEK
WORKER'S COMPENSATION CARRIER NAME AND ADDRESS			
AMOUNTS OF ALL INSURANCE WITH CAREAMERICA LIFE SHIELD LIFE		CLASS	
EMPLOYER;S NAME		REPRESENTATIVE AND TITLE	

STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE NO. ( )

ATTACHMENTS

Important Information Please Attach:

1. Original Enrollment
2. Copy of Job Description
3. Copy of Employment Application or Resumé

ATTENDING PHYSICIAN'S STATEMENT *Please print*

NAME OF CLAIMANT | DATE OF BIRTH

PRIMARY SICKNESS OR INJURY CAUSING INABILITY TO WORK (describe complications, if any):

WHEN DID SYMPTOMS FIRST APPEAR/ACCIDENT HAPPEN? | WHEN DID PATIENT CEASE WORK BECAUSE OF DISABILITY?

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION?

☐ Yes ☐ No If YES, please explain:

DATE OF FIRST VISIT | DATE OF LAST VISIT

FREQUENCY OF VISITS:

☐ Weekly ☐ Monthly ☐ Semi-Annually ☐ Annually ☐ Other (specify):

WHAT PROGRESS IS THE PATIENT MAKING IN REGARD TO THIS CONDITION?

(Check One) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

PLANNED COURSE OF TREATMENT (include expected duration, surgeries, etc.)

IF PATIENT WAS HOSPITALIZED, NAME OF HOSPITAL

ADDRESS | CITY | STATE | ZIP

Admitted: _____/_____/_____/ Discharged: _____/_____/_____/ (Please attach operative reports and discharge summary)

MEDICAL PROGNOSIS (Please include any changes in physical and mental limitations and work activity restrictions)

WHEN DO YOU THINK PATIENT CAN RETURN TO WORK?

Anticipated date: _____/_____/_____/ or ☐ Unable to determine, follow-up in _____ months.

Remarks: _____

IN YOUR OPINION, IS THE PATIENT A CANDIDATE FOR REHABILITATION?

☐ YES ☐ NO

Remarks: _____

ATTENDING PHYSICIAN (please print)
NAME | TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP

SPECIALTY/DEGREE | DATE

SIGNATURE | TAXPAYER ID NO.