

# Equitable Reserve Association

A Not-For-Profit Fraternal Life Insurance Association, est. 1897

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## **Instructions for Proof of Disability & Physician's Statement of Disability**

If your policy has a Waiver of Premium rider attached and you are totally disabled for a period of at least six (6) consecutive months, as defined in your policy, while the rider is in force, the Association will waive your premiums for the period you are totally disabled.

In order for us to give consideration to premium waiver, it will be necessary that you complete the forms giving us full information. Complete Form 1786 with your signature being confirmed in the presence of a notary, and Financial and Medical Records Authorization Form 426. Your attending physician should complete Form 1787, without expense to the Association. Return all forms to us so that we may give consideration to any possible premium waiver benefits.

Mail completed forms to:  
Equitable Reserve Association  
Attn: Claims Department  
P.O. Box 448  
Neenah, WI 54957-0448

***Keep a copy of the completed forms for your records.***

Call the Claims Department at 1-800-722-1574 if you have any questions or concerns.



116 S. Commercial Street • Neenah, Wisconsin 54956

**FINANCIAL AND MEDICAL RECORDS AUTHORIZATION**

(This authorization complies with the HIPAA Privacy Rule)

Purpose: Consideration of a Life Insurance or Disability Income Insurance Application

**Give completed and signed copy to the proposed insured.**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB) or health care provider that has provided payment, treatment or services to me ("My Providers") to disclose the entire medical record and any other protected health information concerning me to Equitable Reserve Association and their agents, employees and representatives. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by #164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Equitable Reserve Association, 116 S. Commercial Street, Neenah, WI 54956, Attention: New Business Department. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that Equitable Reserve Association has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Equitable Reserve Association will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Equitable Reserve Association may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

SSN of Proposed Insured \_\_\_\_\_

Date of Birth of Proposed Insured \_\_\_\_\_

Address \_\_\_\_\_

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Life Insurance Claim

All questions on this form should be fully answered by the insured if competent to do so. If not, and if no guardian has been appointed, the form may be completed by the beneficiary or a close relative. If a guardian has been appointed, the form should be completed by the guardian and a certified copy of letters or guardianship forwarded. By furnishing this blank and investigating the claim the company shall not be admit the validity of any claim or to waive the breach of any condition of the policy. (Use back of sheet if space provided is inadequate).

### IMPORTANT

Continue Premium Payments Until You Are Notified Of Claim Action

Full Name of Insured		Date of Birth
Policy Numbers		
Occupation and Nature of Duties at commencement of Disability		
Employer	Business Address	
Date when your health first began to be affected:	Date you became totally disabled so as to be prevented from doing any work:	
Describe the cause of your disability		
Are you now totally disabled and unable to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes", show date you expect to return to work:	If "no", show date you returned to work:	
State briefly your present daily activities		

What physicians have you consulted during your present disability?

Name and Address	Dates Consulted (From - To)

What other physicians, not mentioned above, have you consulted during the last five years?

Name and Address	Dates Consulted	Disease or Condition

List below the names and addresses of all hospitals or institutions where you have been confined or treated during the past five years.

Name and Address	Dates	Disease or Condition

List all other life and health insurance policies which contain disability benefits.

Name of Company	Policy Date	AMOUNT OF POLICY		HEALTH
		Face Amount	Check if policy provides income benefit	Weekly or Monthly Benefit

I DECLARE that the statements and answers in this application are complete and true to the best knowledge and belief of the undersigned.

Date	Signature of Insured (or Guardian)				
Witness	Mailing Address	Street	City	State	Zip

# Equitable Reserve Association

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Name of Patient		Date of Birth	Policy No.	
Present Address	Street Address	City	State (or Providence)	Zip Code
If Group Insurance, give name of policyholder (i.e., Employer, Union or Association through whom insured)				

## ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

A patient is responsible for the completion of this form without expense to the Company.  
Space is available on the reverse side if you wish to amplify your answers.

### 1. HISTORY

- (a) When did symptoms first appear or accident happen? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 (b) Date patient ceased work because of disability. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 (c) Has patient ever had same or similar condition? Yes  No   
 If yes, state when and describe.  
 (d) Have you ever treated patient prior to this illness? Yes  No   
 If so, for what and when?

### 2. PRESENT CONDITION

- (a) Subjective symptoms.  
 (b) Objective findings. (Include results of current X-rays, EKG's, or any other special tests.)  
 (c) Is patient: Ambulatory?  Bed confined?  House confined?  Hospital confined?

### 3. DIAGNOSIS

### 4. TREATMENT

- (a) Date of first visit. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 (b) Date of last visit. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 (c) Frequency of visits. Weekly  Monthly  Other \_\_\_\_\_  
 (d) When did you last examine the patient? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

### 5. PROGRESS

Recovered  Improved  Unimproved  Retrogressed

### 6. EXTENT OF DISABILITY

- |  | FOR ANY<br>OCCUPATION                                    | FOR HIS REGULAR<br>OCCUPATION                            |
|--|--|--|
| (a) Is patient now totally disabled and unable to do any work?         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (b) If no, when was patient able to do any work?                       | _____<br>Mo. Day Year                                    | _____<br>Mo. Day Year                                    |
| (c) If yes, when do you think patient will be able to resume any work? | _____<br>Mo. Day Year                                    | _____<br>Mo. Day Year                                    |
| Approximate Date   | Mo. Day Year   | Mo. Day Year   |
| Indefinite   | <input type="checkbox"/>                                 | <input type="checkbox"/>                                 |
| Never  | <input type="checkbox"/>                                 | <input type="checkbox"/>                                 |

**7. MENTAL CONDITION**

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes  No

Complete appropriate section, if disability is due to **CARDIAC CONDITION** or **VISUAL IMPAIRMENT**

**8. CARDIAC**

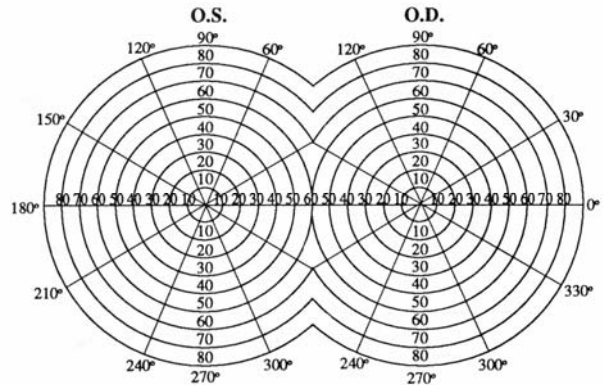
(a) Functional capacity (American Heart Ass'n) Class 1 (No limitation)  Class 2 (Slight limitation)   
 Class 3 (Marked limitation)  Class 4 (Complete limitation)   
 (b) Blood pressure \_\_\_\_\_

**9. VISUAL IMPAIRMENT**

(Snellen Notation)

(a) What was vision at last observation? With Glasses O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Mo. Day Year  
 Without Glasses O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Mo. Day Year

(b) If fields of vision are contracted, show contraction on chart.



(c) Date corrected vision was irrecoverably reduced to 20/20 or less in the better eye. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ O.D.  O.S.

(d) Vision can be restored in whole or in part by: O.D. Lenses  Treatment  Operation  Not restorable   
 O.S. Lenses  Treatment  Operation  Not restorable

**REMARKS**

Date \_\_\_\_\_ Signature (Attending Physician) \_\_\_\_\_ Degree \_\_\_\_\_ Telephone \_\_\_\_\_

Street Address \_\_\_\_\_ City or Town \_\_\_\_\_ State (or Province) \_\_\_\_\_ Zip Code \_\_\_\_\_