

ENTERPRISE LIFE INSURANCE COMPANY/UNION SECURITY LIFE INSURANCE COMPANY

PO BOX 167667 IRVING, TEXAS 75016-7667
972-445-8300, ext. #8702 OR 800-527-1984, ext. #8702

MONTHLY CONTINUATION CLAIM FORM
STATEMENT OF INSURED

CLAIM #: _____

Please update your current status by fully answering all questions and signing the authorization below:

Have you returned to work? _____ If yes, date: _____ Full-time [] Part-time []

Your current disabling condition(s): _____

Please list all medications that you are currently taking: _____

Your current attending physician(s) full name(s), address(es), and phone number(s): _____

Have you applied for or are you receiving any other benefits, such as unemployment or social security? _____

If yes, Date awarded: _____ File #- _____ Type of Benefits: _____

Are you currently engaged in any occupation? If yes, please describe your occupation and duties: _____

Please describe your daily activities: _____

AUTHORIZATION: I hereby authorize any physician, hospital, insurance company, employer, contractor, or other organization to release information regarding my medical history, treatment, disability, or employment history to Enterprise Life Insurance Company/ Union Security Life Insurance Company. A Photostat of this authorization should be as valid as the original. The information I authorize for release may include information that could be considered information about communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, alcohol or chemical dependency, mental or nervous disorders, and the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

DATED: _____ Signed: _____ Print name: _____

ATTENDING PHYSICIAN S STATEMENT

SINCE LAST REPORT:

Please list current disabling conditions/diagnosis: _____

Dates of hospital confinements: _____

Dates of all recent treatments/visits: _____

Any surgery performed or recommended? Yes [] No [] If yes, Date: _____

Name of the operation: _____

What level of work is the patient capable of performing? Heavy [] Medium [] Light [] Sedentary [] None []

What specific medical restrictions prevent the patient from returning to previous occupations? _____

What specific medical restrictions prevent the patient from returning to any gainful employment? _____

Date patient will be able to return to previous occupation? _____ Actual [] Estimated []

Date patient will be able to return to any gainful employment? _____ Actual [] Estimated []

PATIENT WAS UNDER MY CARE AND CONTINUOUSLY TOTALLY DISABLED:

A. Unable to perform Regular occupation: From: _____ To: _____

B. Unable to perform Any occupation: From: _____ To: _____

Full address: _____ Phone number: _____

Date: _____ Signature: _____ M.D. or D.O. (circle one)

EMPLOYER'S STATEMENT

What is this Employee's occupation? _____ Duties _____

Date Employee was first off work due to this disability: _____

What level of work does this Employee's REGULAR job duties require? Heavy [] Medium [] Light [] Sedentary []

Is there light duty work available for this Employee? Yes [] No []

Has the Employee returned to work? Yes [] No [] If yes, Date: _____ Part-time [] Full-time []

If no, Date Expected to return to work: _____ Part-time [] Full-time [] Compensation Case? Yes [] No []

Compensation Case #- _____ Carrier Name: _____ Phone number: _____

Business Name: _____ Phone number: _____

Full Address: _____

Date: _____ Signature: _____ Printed Name/Title: _____