



NATIONAL INCOME LIFE INSURANCE COMPANY

c/o National Income Life Service Center
P.O. Box 2608 Waco, Texas 76797

1. Claim Form Must Be Completed By INSURED, DOCTOR and, for disability claims only, the EMPLOYER.
2. Mail With The Claim Form All Itemized Doctor and Hospital Bills.
3. Mail The Form In Yourself. Do Not Leave It For The Doctor to Mail.

PART A CLAIMANT'S STATEMENT - TO BE COMPLETED ON ALL CLAIMS					
Policy Numbers <input style="width: 150px; height: 20px;" type="text"/> <input style="width: 150px; height: 20px;" type="text"/> <input style="width: 150px; height: 20px;" type="text"/> <input style="width: 150px; height: 20px;" type="text"/>					
Policyowner's name			Policyowner's address		
Policyowner's employer					
Policyowner's union and local			Policyowner's occupation		
Patient's name			Names of other insurance companies which cover this claim		
Patient's birthdate		Relation to policyowner			
List the names and addresses of doctors consulted for this accident or sickness and dates of treatment.					
DOCTOR		ADDRESS		DATES	
If hospitalized, name and address of hospitals and dates of confinement.					
HOSPITAL		ADDRESS		DATES	
Date that symptoms first appeared			Date of first treatment by doctor		
Nature of sickness or accident			If an accident, how did it happen?		Date of accident
Have you ever had symptoms of this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No When?					
Date required to give up work			Date returned to work		
List all sickness or injuries for which treatment was required in the past five years.					
CONDITION		DATE		CONDITION	

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation..

Claimant's Signature **X** _____

E-mail address _____

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the National Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with National Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Patient's Signature **X** _____

Date _____

Patient's Address _____

Phone # _____



