LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349, GADSDEN, AL 35902

CLAIMANT'S STATEMENT FOR DISABILITY CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please submit the completed form to the above address along with the following information:

(1) An Accident or Police Report is required for all Motor Vehicle Accidents.
(2) Medical certification is required for the entire period you are disabled.

POLICYHOLDERS NAME _____ POLICY NO(S) _____

ADDRESS _____

PHONE _____-_____-_____ SS# _____-_____-_____ DATE OF BIRTH _____-_____-_____

❑ Check here if New Address Male ❑ Female

THIS CLAIM IS ON: ❑ Insured ❑ Your Spouse ❑ Your Child ❑ Male ❑ Female

If the claim is on your spouse or child, please complete the following:

Patient's Name _____ SS#_____-_____-_____

Date of Birth _____-_____-_____ Relationship to Policyholder_____

What condition are you claiming? _____

Date Physician was first consulted for this condition _____

Primary Physician'sName:_____

Address _____ Phone No _____-_____-_____

1st Physician's Name _____ Phone No _____-_____-_____

Address _____

2nd Physician's Name _____ Phone No _____-_____-_____

Address _____

If you were hospitalized: Date Admitted _____-_____-_____ Date Discharged _____-_____-_____

Name of Hospital _____ Phone No _____-_____-_____

Address of Hospital _____

Date injured_____-_____-_____ Time of Accident _____ Where did accident happen?_____

Tell us exactly how the accident happened _____

_____

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

I certify the above information is true to the best of my knowledge.

_____ _____

Signature Date