



PEKIN LIFE INSURANCE COMPANY
 2505 COURT STREET, PEKIN, ILLINOIS 61558
 Instruction to creditor
 (Complete this section before giving form to insured)

Name of Insured in full _____
 Insured's Policy/Certificate No. _____ Loan Account No. _____ Term of Loan _____
 Date of Loan _____ Due Date of 1st Loan Payment _____ Creditor Code # _____
 Creditor _____
 Creditor's Address _____ City _____ State _____ Zip _____
 Completed by _____ Title _____ Date _____ Phone No. _____

IF MOB: Attach Amortization schedule as of last advance, prior to disability date

STATEMENT OF THE INSURED

Enter the last 4 digits of your SS #

Claim form should be completed after waiting period is fulfilled.

Insured's Name _____ Date of Birth _____
 Address _____ Tel. No. _____

Employer's Names and Addresses (If more than one, list all) _____ Occupations _____
 _____ Duties _____

Employer(s) when you purchased this insurance. (Name, Address, & Phone Number) _____

1. Describe injury or sickness fully. _____
2. If accident, give details. Date _____ AM PM Where? _____
 How? _____
3. When were first symptoms noticed? Date _____ Describe _____
- 4 (a). Name and address of first doctor consulted _____
 (b). Date Consulted _____
 (c). Name and address of hospital _____
 Dates confined _____ From _____ To _____
5. Name and address of family doctor _____
6. Names and addresses _____ NAME _____ ADDRESS _____ DATE _____
 of all other doctors _____
 consulted _____
7. Has same or similar condition occurred before? Yes No If yes, when? _____
 Doctor _____
8. (a). Last date worked. _____ (b). First date of disability _____
9. Are you applying for or receiving state unemployment benefits Yes No Date began _____ Date ended _____
10. Date you returned to any work _____ Was this any part of your regular duties? Yes No
11. If you have not returned to work, when do you expect to? _____

Indiana Claims: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Ohio Claims: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

ASSIGNMENT

I hereby assign, transfer and set over my interest in the above numbered policy, and direct that benefits payable to me under said policy be paid to the financial institution named in the policy or certificate as their interest may appear. The above assignee's receipt for benefits that may be due or become due me shall be a full acquittance of all claim under the said policy to the extent that benefits are paid under this assignment. I hereby certify that the answers given above are full and true. Any information not reported, or information reported that is not true, may be used to deny a claim and/or void coverage in accordance with the provisions of the Department of Insurance. It is agreed that the furnishing of this form or its acceptance by the company as proof does not constitute an admission of any liability, nor a waiver of any of the conditions of the insurance contract.

Pekin Life Insurance Company or its representatives are hereby authorized to examine and secure copies of any medical, employment, governmental, insurance company or other records of information. A copy of this authorization shall be considered as valid as the original. Valid for the duration of this claim. I may receive a copy of this authorization upon request.

_____, _____
 DATE SIGNATURE OF INSURED

_____, _____, _____, _____
 STREET ADDRESS CITY OR TOWN STATE ZIP



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CLAIM DIVISION

DISABILITY
ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM - GROUP OR INDIVIDUAL
(To be completed entirely by Doctor's Office)

PATIENT'S NAME AND ADDRESS _____ AGE _____

1. Diagnosis and concurrent conditions. _____

2. (a). Is condition due to injury or sickness arising out of patient's employment? [] yes [] no If yes, explain _____

(b). Is condition due to pregnancy? [] yes [] no If yes, approximate date pregnancy began _____

3. (a). Date of accident or first symptoms of illness _____ (b). Date patient first consulted you for this condition _____

(c). Give all other dates of treatment in office _____

(d). If patient was hospitalized, name and address of hospital _____

(e). Dates Hospitalized _____

(f). Nature of surgical procedure, if any _____ Date performed _____

4. Has patient ever had same or similar condition? [] yes [] no If yes, when _____

5. Is patient still under your care for this condition? [] yes [] no If no, date last treated _____

6. (a). Dates patient was totally disabled (Unable to work) From _____ To _____

(b). Dates patient was partially disabled From _____ To _____ w/ restrictions of: _____

(c). If disability continuing, when will patient be able to return to work? _____

SIGNATURE (ATTENDING PHYSICIAN) _____ DEGREE _____ DATE _____ PHONE NUMBER _____

ATTENDING PHYSICIAN'S NAME (PRINT) _____ FEDERAL TAX I.D. NUMBER _____ FAX NUMBER _____

STREET ADDRESS _____ CITY OR TOWN _____ STATE _____ ZIP CODE _____

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EMPLOYER'S REPORT

CLAIM DIVISION

Policy No./Certificate No. _____

To be completed by the employer, timekeeper or superior officer under whom employee was working when disabled.

Name of Employee _____ Last 4 Digits of Social Security #

1. Date first employed by your company _____
2. On what date did accident occur or sickness commence? _____ hour _____ AM PM
3. On what date did employee stop work? _____ hour _____ AM PM
4. What is employee's occupation? _____ What are employee's usual duties? _____

5. Full time employee? yes no
Within the last two years, has employee ever worked less than 30 hours per week (other than vacation)? yes no
If yes, please list dates _____
Part time employee? yes no If part time, how many hours worked per week? _____
6. On what date did employee first return to work? _____ hour _____ AM PM
7. If partially disabled, what duties of employee's regular job was he/she able to perform? _____
8. On what date did employee return to full duty? _____ hour _____ AM PM
9. If still disabled, is position being held for employee? yes no

Name of Employer _____

Signature _____

Address _____

Official Position _____

Date _____

Telephone Number () _____

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