MOTHE LIFE INSURANCE COMPANY

CLAIMANT'S STATEMENT FOR ACCIDENT OR SICKNESS

OUR CLAIM IS FOR DAYS IN THE HOSPITAL: 1) Please answer all questions on this side fully; 2) Be sure you sign this side on the last line; 3) On the second page put a check mark in box #1; 4) Have your doctor answer all the questions on the second page; 5) Attach a copy of your hospital bill.

OUR CLAIM IS FOR DAYS RECUPERATING FROM HOSPITAL CONFINEMENT: (*Remember you must have spent 7 consecutive days in the hospital before you can receive a recuperative benefit.)* 1) Please answer only the questions in the shaded boxes; 2) Be sure you sign on the last line; 3) On the top of the second page put a check mark in box #2; 4) Have your doctor answer only the questions in the shaded boxes on the second page.

Name Insured	Policy #
Present Address	SSN
Occupation at date disability began? (list all)	Date of Birth MO DAY YEAR
Describe duties fully	Salary per month
Name & Address of Employer	

BASIS FOR CLAIM (Complete the column which applies)

ACCIDENT	**SICKNESS**
Date of Accident MO DAY YEAR HOUR _____AM _____PM	Date of Sickness MO DAY YEAR HOUR _____AM _____PM
How and where did accident happen? (Explain Fully)	Nature of Sickness
Describe Injuries	Date of First Symptoms

DAILY HOSPITAL BENEFIT

Names and addresses of all physicians who have treated you for this disability			
Date first confined to hospital	Name of Hospital	Address	From To
Date released from hospital			

DAILY RECUPERATIVE BENEFIT

When did your disability force you to cease all work?	MO	DAY	YEAR	HOUR _____AM	_____PM
Date you were first confined to house	MO	DAY	YEAR	HOUR _____AM	_____PM

LIST ALL OTHER POLICIES ISSUED BY OUR COMPANY COVERING THIS DISABILITY	POLICY NUMBERS				
WHAT INSURANCE HAVE YOU WITH OTHER COMPANIES?	NAME OF COMPANY			POLICY DATE	WEEKLY OR MONTHLY BENEFITS
HOW MANY TIMES HAVE YOU BEEN DISABLED IN THE PAST FIVE YEARS?	CAUSE OF DISABILITY	DATE	DURATION	DOCTOR'S NAME AND ADDRESS	

The Mothe Life Insurance Company, Gretna, Louisiana:

I do hereby authorize any physical, or any other person who has attended or examined me, or any hospital in which I may have been treated to disclose any knowledge or information which was thereby acquired.

Date _____ Signed _____

ATTENDING PHYSICIAN'S STATEMENT

1 Your Patient is claiming benefits for a period of hospital confinement - or of hospital confinement and recuperation not in the hospital. Please respond the following fully

2 Your Patient is claiming benefits for a period of recuperation, answer only the questions in the shaded boxes.

Patient's Name		Age	Address
(1) Nature of sickness or name of cancer. Describe complications, if any. Is condition due to pregnancy?	_____Yes _____No What was approximate commencement date?		
(2) When did symptoms first appear or accident happen?		(3) When did patient first consult you for this condition?	
(4) Has patient ever had same or similar condition? If "yes" state when and describe	_____Yes _____No		
(5) Has patient been treated by you for any other sickness or injury during the past five years? If "yes" state when and describe.			
(6) Describe any other disease or infirmity affecting present condition.			
(7) Nature of surgical or obstetrical procedure, if any. Give date and describe fully.	At your Office	At Patient's Home	At Hospital (ERCP)
(8) Give dates of treatments.			
(9) Is patient still under your care for this condition?	_____Yes _____No If "no" give date discharged		
(10) Is patient still under your care for this condition?			
(11) How long was or will patient be continuously totally disabled (unable to work)?	From Through		
(12) Have you filled out any other claim forms for this disability? If "yes," give names and addresses of the companies.	_____Yes _____No		
(13) Remarks:			
Signed by:_____ Degree: _____ Date: _____			
Individual Practitioner's SSN		All Others - Employer ID#	
Must be furnished under authority of law			
Address			

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