**ASSURITY LIFE INSURANCE COMPANY**
1526 K Street - PO Box 82533
Lincoln, NE 68501-2533
Toll Free 800-869-0355 • Fax 402-437-4592

# CRITICAL ILLNESS CLAIM QUESTIONNAIRE TO BE COMPLETED BY CLAIMANT

**1. PERSONAL INFORMATION** Policy number ____________________

Name: ________________________________________________________
Last Name First Name

Date of birth: ____________________ Telephone: Home: (____) ____-__________
Office (____) ____-__________

Address: ________________________________________________________
________________________________________________________

**2. DETAILS OF CRITICAL ILLNESS:**

a) Please describe your illness: ____________________________________________

________________________________________________________

________________________________________________________

Date of diagnosis or operation ____________________

b) When did the first symptoms appear? Please describe the symptoms:

________________________________________________________

________________________________________________________

c) When did you first consult a Physician for this condition?

________________________________________________________

Name & address of that attending Physician:

________________________________________________________

d) Please provide details and dates of tests or exams to confirm the diagnosis?

________________________________________________________

________________________________________________________

e) Did you previously suffer from or receive treatment for the same or a similar condition? If yes, please provide details and dates:

________________________________________________________

________________________________________________________

**3. MEDICAL CONSULTATIONS**

a) Name and address of your personal Physician: ____________________________________

________________________________________________________

b) Names, addresses and dates seen of any other Physicians or specialists consulted for this disease:

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c) Name, address, date admitted and discharged from any hospital or other medical facility:

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d) Describe current and past treatments for this disease:
Type of treatment Hospital/Institution / Treating Physician Dates

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**4. GENERAL INFORMATION**

a) Has anyone in your direct family (parents or siblings) suffered from this or similar disease? If yes, please provide:

Relationship Disease Age when first diagnosed

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b) Please provide any other information that may be useful in the assessment of your claim.

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**5. DECLARATION AND AUTHORIZATION**

**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 also be subject to a substantial civil penalty where and to the extent allowed by state law.**

**I hereby agree to reimburse Assurity Life Insurance Company to the extent of any overpayment which is in excess of the amounts payable under the individual plan administered by Assurity Life Insurance Company. I hereby certify the statements hereon are complete and accurate to the best of my knowledge.**

**Date:** ____________________ **Signature:** ________________________________________