



**APPLICATION FOR INDIVIDUAL BENEFITS**

PO Box 82533  
Lincoln, NE 68501-2533

Toll Free 866-289-7337  
Fax 800-869-0368

1. Name of Policyowner \_\_\_\_\_  
 Last First Middle Policy Number(s) \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Phone Number \_\_\_\_\_
2. Name of Patient (if different from policyowner) \_\_\_\_\_
3. Business or occupation \_\_\_\_\_
4. Employer's name \_\_\_\_\_  
 Employer's address \_\_\_\_\_  
 Street City State Zip Code
5. When did the physician first treat you? \_\_\_\_\_  
 Give other dates of treatment \_\_\_\_\_
6. Name of treating physician(s) \_\_\_\_\_  
 Physician(s) address and phone \_\_\_\_\_
7. Full name of your primary care physician \_\_\_\_\_  
 Address and phone number \_\_\_\_\_
8. If accident, when did it happen? \_\_\_\_\_, 200\_\_\_\_. Time of day \_\_\_\_\_  
 How and where did accident happen? \_\_\_\_\_
9. If sickness, when did it begin? \_\_\_\_\_ Nature of illness \_\_\_\_\_  
 Have you ever had this same illness before? Yes No When? \_\_\_\_\_
10. Are you or will you be applying for benefits under any State or Federal Worker's Compensation law? Yes No
11. Were you confined to a hospital? Yes No Was an operation performed? Yes No If yes, describe \_\_\_\_\_  
 Date & Time entered \_\_\_\_\_ Date & Time discharged \_\_\_\_\_  
 Name of hospital \_\_\_\_\_  
 Address & Phone of hospital \_\_\_\_\_

If you are applying for **DISABILITY BENEFITS**, please complete:

12. On what date did you stop performing all of your employment duties? \_\_\_\_\_
13. When did or do you expect to return to some of your employment duties? \_\_\_\_\_
14. When did or do you expect to return to all of your employment duties? \_\_\_\_\_

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**

I hereby agree to reimburse Assurity to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(cies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

SIGNATURE OF POLICYOWNER \_\_\_\_\_ Date \_\_\_\_\_

**DISABILITY BENEFITS ARE SUBJECT TO PERIODIC REVIEW**

**Mail claim form to address listed above**  
Make copies for your records