1015-1 DISABILITY BENEFIT ACTIVATION 14 R

IMPORTANT: DO NOT COMPLETE ANY OF THIS FORM UNTIL YOU HAVE BEEN TOTALLY DISABLED FOR 14 DAYS. IF THIS FORM IS COMPLETED PRIOR TO THE 14 DAY WAITING PERIOD, WE WILL NOT BE ABLE TO ACCEPT IT.

FILL OUT PART ONE, BE SURE TO COMPLETE FIELDS #1 THROUGH #26 b

PRINT THE FORM AFTER COMPLETING THE ABOVE INDICATED FIELDS

SIGN AND DATE THE BOTTOM OF PAGE ONE

PAGE TWO NEEDS TO BE COMPLETED BY YOUR PHYSICIAN

PAGE THREE NEEDS TO BE COMPLETED BY YOUR EMPLOYER

RETURN ALL THREE COMPLETED PAGES TO:

PEKIN LIFE INSURANCE COMPANY
ATTN: FINANCIAL PRODUCTS BENEFITS DEPT.
2505 COURT STREET
PEKIN IL 61558

309-346-1161, x2329

Reset

Disability 14 Day Retro
Benefits Activation Form

FINANCIAL INSTITUTION – COMPLETE THIS SECTION BEFORE GIVING FORM TO PROTECTED BORROWER

Name of Insured in full _____

Customer ID number _____ Term of Loan _____ Loan Date _____

Creditor _____ Agent # _____

Completed by _____ Title _____ Date _____ Phone _____

Disability Benefits Activation Form must be signed and dated by the attending physician 14 days or more after the start of the disability. Protected Borrower Disability Authorization Form must be signed and dated by the Protected Borrower 14 days or more after the start of the disability.

Please complete all fields. Missing information may cause processing delays.

Part 1 – To be completed by Protected Borrower

1. Customer ID Number	2. Last 4 Digits of Social Security Number	3. Date of Birth		
4. Last Name	5. First Name	6. Middle Initial		
7. Address	8. City	8a. State	8b. Zip Code	
9. Phone Number	10. Has your loan been refinanced? ❑ Yes ❑ No If yes, please provide prior loan number.			
11. Date of Disability Beginning (mo-day-yr) End (mo-day-yr)	12. Is disability due to injury? ❑ Yes ❑ No If yes, please provide date of injury (mo-day-yr)			
13. How did the injury occur?	14. Date you were first treated for your illness or injury (mo-day-yr)			
15. Dates Hospitalized: _____ to _____	16. Name & Phone Number of Hospital _____ _____			
17. Attending Physician's Name	18. Attending Physician's Phone Number (Required)			
19. Attending Physician's Fax Number (Required)	20. Attending Physician's Street Address/City/State/Zip Code			
21a. After becoming disabled, have you worked for wages or profit in your occupation? ❑ Yes ❑ No If yes, please see 21b and 21c. 21b. Please provide start date (mo-day-yr) and end date (mo-day-yr). _____ 21c. Are you still working? ❑ Yes ❑ No				
22. Primary Physician Name (if different from #17)	23. Phone Number (Required)	24. Fax Number (Required)		
25. Street Address	26. City	26a. State	26b. Zip Code	

I hereby certify that the answers given above are full and true.

_____ _____

Signature **Date**

Return completed forms to:
Pekin Life Insurance Company, Financial Products Benefit Activation, 2505 Court Street, Pekin, IL 61558.
CL 1015-1 (11-07)

Disability 14 Day Retro Benefits Activation Form – Page 2

Please complete all fields. Missing information may cause processing delays.

Part 2 – To be completed by Physician

27. Diagnosis and Concurrent Condition	28. Has this patient been treated for this condition before? ❑ Yes ❑ No If yes, please include dates. (mo-day-yr)		
29. Since the start date of disability is this patient under your continuous care? ❑ Yes ❑ No			
30. Date this patient was unable to perform the principal duties of the occupation held when he/she became disabled. (mo-day-yr)			
31. Was patient hospitalized ❑ Yes ❑ No	32. Name of Hospital	33. Hospital admission date (mo-day-yr)	
34. Hospital release date (mo-day-yr)	35. If applicable, return to work date (mo-day-yr)		
36. Was surgery performed on this patient? ❑ Yes ❑ No			
37. Is disability due to: (please mark one) ❑ Sickness ❑ Injury, please specify date of injury (mo-day-yr). Please see 38. ❑ Work related injury, please specify date of injury (mo-day-yr). Please see 38. ❑ Pregnancy – Was pregnancy normal? ❑ Yes ❑ No (If no, please list complications)			
38. If disability was due to an injury, was that injury self-inflicted, due to a commission of an assault or felony, foreign travel, or flight in non-scheduled aircraft? ❑ Yes ❑ No			
39. In your expert opinion, how would you qualify this patient – please mark one: ❑ Permanently Disabled ❑ Temporarily Disabled ❑ Non-Disabled			
40. Was this patient referred to you by another Physician? ❑ Yes ❑ No	41. If yes, please provide Physician's name.		
42. Referring Physician's Street Address	43. City	43a.State	43b. Zip
44. Please provide complete name and address of any other treating Physician(s) or Hospital(s). If extra space is needed, please submit on a separate sheet of paper.			
45. Attending Physician's Printed Name			
46. Street Address	46a. City	46b. State	46c. Zip
47. Phone Number (Required)	48. Fax Number (Required)		
49. Attending Physician's Signature		50. Date	

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Disability 14 Day Retro Benefits Activation Form – Page 3

<u>Part 3 – To be completed by Employer</u> – If self employed, please provide copy of business license, in addition to completing Part 3.

51. Company Name	52. Company Address		
53. City	53a. State	53b. Zip	54. Hire Date (mo-day-yr)
55. Last date of work before employee became disabled (mo-day-yr)	56. Date employee became disabled (mo-day-yr)		
57. If the last date of work and the date the employee became disabled are not consecutive, please explain.			
58. Employee return to work date, if applicable (mo-day-yr)	59. Employee paid through date (mo-day-yr)		
60. Did employee work at least 30 hours per week for the 30 days prior to start date of disability? ❑ Yes ❑ No If no, please complete 60a.			
60a. Reason for not working 30 hours per week for the 30 days prior to start date of disability: ❑ Sick/Vacation, list days _____ ❑ Part time Employment ❑ Other, please specify			
61. Employee's Occupation and Job Duties			
62. Employer/Manager Full Name	63. Employer/Manager Title	64. Phone Number (Required)	
65. Fax Number (Required)	66. Signature	67. Date	

Return completed forms to:
Pekin Life Insurance Company, Financial Products Benefit Activation, 2505 Court Street, Pekin, IL 61558.