PACIFIC GUARDIAN LIFE

APPLICATION FOR DISABILITY BENEFITS
(Continuation of Coverage)

For your protection California laws and the laws of some states require the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

This Statement must be completed by the employee. If the employee is mentally incompetent, the statement should be completed by the guardian, or if none has been appointed, by the beneficiary named in the policy.

Claimant's Name: Social Security Number:

Date of Birth: Sex: ❑ Male ❑ Female Marital Status:

Address:

Name of Group Policyholder: Group Policy No.

Name of Last Employer: Date Last Worked:

Address:

Complete the following statements concerning your disability:

1. State Cause of Disability:
2. Date first unable to work because of sickness or accident:
3. Name and Address on any Employer since date given in Item 2. (if none, please state)
4. Date first treated by a physician:
5. Date last treated by a physician for this disability:
6. What activities can you now perform?
7. Name all physicians who have treated you since the beginning of this disability:
8. If your disability is due to an accident, please answer the following questions:
   a. Were you engaged in your regular occupation when the accident occurred? ❑ Yes ❑ No
   b. When and where did the accident occur?
   c. Describe the accident. How did it occur?
9. List other insurance carried in this or other companies under which you receive waiver of premium or income benefit due to disability:
10. Give source and amount of present income derived from other than insurance policies:

I authorize any physician, hospital or association to disclose to any representative of the Pacific Guardian Life Insurance Co., Ltd., any information regarding my past health history or present disability. I agree that a photocopy of this authorization may be used in lieu of this original.

Date Signature of Employee

Policyholder's Statement

1. Effective date of Employee's Insurance:
2. Insurance Amount: $
3. Last premium paid (Mo./Yr):
4. Has insurance terminated? ❑ Yes ❑ No If "Yes", give date and reason:

Date Authorized Representative

Date Policyholder

Have your physician complete the Attending Physician's or Surgeon's Statement Section

Pacific Guardian Life, 1440 Kapiolani Blvd., Suite 1700, Honolulu, Hawaii 96814

ATTENDING PHYSICIAN'S OR SURGEON'S STATEMENT

The patient is responsible for the completion of this form without expense to the Company.

Patient's Full Name (Print): Date of Birth:

Present address:

HISTORY

1. When did symptoms first appear or accident happen?
2. Date patient ceased work because of disability:
3. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe:

PRESENT CONDITION

1. Subjective symptoms:
2. Objective findings (include results of current X-rays, EKGs, or any other special tests):
3. Patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

DIAGNOSIS

TREATMENT

1. Date of first visit:
2. Date of last visit:
3. Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other
4. When did you last examine the patient?

PROGRESS

☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

EXTENT OF DISABILITY

	For Any Occupation	For Patient's Regular Occupation
1. Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
2. If "No", when was patient able to go to work?	Date:	Date:
3. If "Yes", when do you think patient will be able to resume any work?		
a. Approximate date:	Date:	Date:
b. Indefinite	☐ Indefinite	☐ Indefinite
c. Never	☐ Never	☐ Never
4. If "Yes", is patient a suitable candidate for rehabilitation program?	☐ Yes	☐ No

MENTAL CONDITION

Is patient competent enough to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Name of Attending Physician: Telephone No.:

Office address:

Signature of Attending Physician Date

PHYSICIAN: Return the completed form to Pacific Guardian Life, Group Dept.-Claims,1440 Kapiolani Blvd., Ste. 1700, Honolulu, HI 96814.