



## REQUEST FOR WAIVER OF LIFE INSURANCE PREMIUM

<b>STATEMENT OF CLAIMANT FOR TOTAL DISABILITY (LIFE ONLY)</b> (Attending Physician must complete and return the Attending Physician's Statement for Total Disability, Employer must complete and return the Statement of Employer for Total Disability)			
Full Name		Date of Birth	
Address	City	State	Zip
Nature of Disability		Date illness or injury began	
Give a full description of your illness or injury. (If an injury, please indicate how, when and where your injury occurred.)			
Last date physically worked by reason of this disability		Date you first consulted a physician for this disability	
Were you confined to a hospital? (If yes, provide the name, address and dates of stay.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name(s) and address(es) of your treating physicians			
If you are no longer totally disabled, what date did you return to work?		If you are currently disabled, what date do you expect to return to work?	
<b>Authorization to Disclose Health-Related Information</b> <b>(This Authorization complies with the HIPAA Privacy Rule)</b>			
I certify that the above statements are complete, true and correctly recorded.			
I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to TruAssure Insurance Company, its employees, agents or representatives (TruAssure). "Information" may include my entire medical record, diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report or any other medical or non-medical information about me.			
The information to be disclosed under this Authorization may be used by TruAssure to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with TruAssure.			

## STATEMENT OF CLAIMANT FOR TOTAL DISABILITY

### Authorization to Disclose Health-Related Information (con't)

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to TruAssure. I am aware that my revocation will not be effective until received by TruAssure and will not be effective regarding the uses and/or disclosures of my Information that TruAssure has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides TruAssure with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent TruAssure from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

Signature of Employee

Date

**MAIL TO: TruAssure Insurance Company, 801 Ogden Avenue, Lisle, IL 60532**

**CONTACT US AT: 800-414-4988 or [GetAnswers@truassure.com](mailto:GetAnswers@truassure.com)**



## REQUEST FOR WAIVER OF LIFE INSURANCE PREMIUM

### ATTENDING PHYSICIAN'S STATEMENT FOR TOTAL DISABILITY (LIFE ONLY)

(Employer must complete and return the Statement of Employer for Total Disability, Employee must complete and return the Statement of Claimant for Total Disability)

Name of Patient	Date of Birth
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#### HISTORY

(a) When did symptoms first appear or accident happen?	(b) Date patient ceased work because of disability?	(c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, state when and describe
(d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(e) Names and addresses of other treating physicians	

#### DIAGNOSIS

(a) Diagnosis (including complications)	(b) If pregnant, estimated date of delivery
(c) Subjective symptoms	(d) Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

#### TREATMENT

(a) Date of first visit	(b) Date of last visit	(c) Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)
Nature of treatment (including surgery and medications prescribed, if any)		

#### PROGRESS

(a) Has patient <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?	(b) Is patient <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House Confined? <input type="checkbox"/> Bed Confined? <input type="checkbox"/> Hospital Confined?
(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, give name and address of hospital	
Confined from _____ through _____	

#### CARDIAC

(a) Functional cardiac capacity (American Heart Association) <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation)	(b) Blood pressure (last visit) Systolic/diastolic _____
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#### IMPAIRMENTS

(a) Physical restrictions/limitations (as defined in the Federal Dictionary of Occupational Titles) <input type="checkbox"/> Class 1- No limitation of functional capacity: capable of heavy work. No restrictions (0-10%) <input type="checkbox"/> Class 2- Medium manual activity (15-30%) <input type="checkbox"/> Class 3- Slight limitation of functional capacity: capable of light work. (35-55%) <input type="checkbox"/> Class 4- Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity. (60-70%) <input type="checkbox"/> Class 5- Severe limitation of functional capacity: incapable of minimum (sedentary) activity. (75-100%)
Remarks:





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<b>STATEMENT OF EMPLOYER FOR TOTAL DISABILITY (LIFE ONLY)</b> (Attending physician must complete and return the Attending Physician's Statement for Total Disability, Employee must complete and return the Statement of Claimant for Total Disability)			
Policy Holder		Policy Number	
Address	City	State	Zip
Claimant's Certificate Number			
Name of Claimant			
Date of Birth	Age at Onset of Disability	Date Claimant Employed	
Occupation		Salary	
Amount of Insurance		Last Date Physically Worked by Claimant	
Reason for Leaving Work			
I HEREBY STATE THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.			
Name of Employer			Date
Signature			Title

**MAIL TO: TruAssure Insurance Company, 801 Ogden Avenue, Lisle, IL 60532**