KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988, Austin, TX 78766-9988
Telephone: 844.613.6245 Fax: 844.473.8084
Email: Service@kemperbenefits.com Website: kemperbenefits.com

WAIVER OF PREMIUM RIDER CLAIM FORM

INSTRUCTIONS:

1. Insured, or if deceased, his/her Spouse or Legal Representative must complete **PART I**.
2. Take form to your physician for completion of **PART II**. Return form to your employer for completion of **PART III**.
3. Completed form (includes PART I – PART III) must be forwarded to the above address or fax number.
4. Do not complete the claim form until you have been disabled for six (6) consecutive months.
5. Premium must be paid during the initial six (6) months of disability.
6. Please attach a copy of your job description.

PART I – EMPLOYEE'S STATEMENT

1. Insured's Full Name (please print)
2. Group Number
3. Date of birth
4. Insured's Full Address
5. Occupation
6. Social Security No.
7. Nature of sickness or injury
8. Sickness
   Have you ever been sick with this condition before? ☐ Yes ☐ No
   Date you first noticed sickness:
9. Date of first medical treatment for this condition:
   Treatment received:
10. Injury
    Date of injury:
    Place:
11. Date you were first unable to work:
12. How did the injury happen?
13. Have you engaged in any work, part-time or otherwise, since your sickness or injury began? ☐ Yes ☐ No
    If yes, please explain and give dates:
14. If you have recovered or return to work, give date.
15. If still totally disabled, when do you expect to return to work?
16. Names and addresses of all physicians who have been consulted because of this condition.
    Name | Address | Date of Consultation/Treatment
17. Have you been confined to a hospital for this disability? ☐ Yes ☐ No If yes, please complete the information below.
    Name of Hospital | Address | Dates of Treatment

Please indicate if there is someone authorized to answer questions about this application if the Policyholder is unable to do so or not available:

Name:____ Phone:______________________________

Address:____Relationship:______________________________

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date ______________________________ Signature of Insured ____

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PART II – PHYSICIAN STATEMENT (Must be completed by physician)

Patient's Full Name:	Date of Birth:
1.Diagnosis and concurrent conditions (if diagnosis code other than ICD-9 used, please give name):	2.Surgeries Performed: Date of Surgeries:
3. Is condition a result of an accident or illness? (check one) ☐ Accident ☐ Illness	
4. Is condition due to injury or sickness arising out of Patient's employment? ☐ Yes ☐ No	
5. Initial date of treatment:	6. Last date of treatment:
7. Date symptoms first appeared or accident happened:	8. Date patient first consulted you for this condition:
9. Patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when and describe:	10. Patient still under your care for this condition? ☐ Yes ☐ No
11.Dates of services since disability commenced:	12.Please indicate any diagnostic tests:
13. Dates unable to work (disabled) own Occupation: From ___________________ Through ____________________ Dates unable to work (disabled) any Occupation: From __________________ Through _____________________ Is the patient permanently disabled? Yes or No	14. If still disabled, date patient should be able to return to work: If patient is unable to work, please give reasons:
Please indicate treatment plans:	
Comments/Restrictions:	
Physician's Name:	Degree:
Address:	
Phone Number:	Fax Number:
Date: By (authorized signature):	

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PART III – EMPLOYER'S STATEMENT (Must be completed by employer)

Full Name of Participant (please print): | Date Employed: | Effective Date of Coverage (under this plan):

Social Security No.: | Weekly Salary Amount: $ _______________ | Annual Salary Amount: $ _______________ | Average hours worked per week:

Status of employment at the time of disability: Full-time Part-time Leave of Absence Terminated Retired
Date: __________ To: _____________

Occupation, position, or title: | Job classification: Sedentary Light Medium Heavy Very Heavy

Describe the participant's job duties, or attach a formal job description. Please be specific.

Date last worked: | Date disability began: | Has participant returned to work? ☐ Yes ☐ No
Date of Return __________________ Full-time _________________
Part-time _________________

Did this disability arise out of, or in the course of, any employment of the participant's?

☐ Yes ☐ No If yes, please explain:

Employer's/Business Entity's Authorized Representative:
Name (please print) __________________________________ Title ______________________ Phone __________________

Employer's Address:

Phone Number: | Fax Number:

Date: | Employer's Signature: