



PO Box 80926
Lincoln, NE 68501

Application for Individual Benefits

Your claim will be reviewed within 15 business days.
You will receive notification in writing.

Toll Free 866-289-7337
Fax 402-437-4592

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