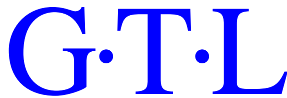

Guarantee Trust Life Insurance Company • www.gtlic.com
P.O. Box 1145 • Glenview, Illinois 60025 • (800) 592-0629

PLEASE HAVE FORM COMPLETED 30 DAYS AFTER: ______/______/________

CONTINUING DISABILITY CLAIM FORM

CLAIM NUMBER: ______________________

Part 1. INSURED'S STATEMENT

A. Name: ______________________________________ Alternate Name:__________________________

Address:______________________________________ If new address please check box □

B. Have you returned to your usual occupation full time? Yes □ No □
If "Yes", please give date retuned: _____/_____/_____

C. Have you returned to part time or limited duty work? Yes □ No □
If "Yes", please describe any limited duties/special hours below, to avoid any delay in the processing of your claim.

____

Insured's Signature:______________________________ Date: _____/_____/_____

Part 2. PHYSICIAN'S STATEMENT (Do not complete this form until 30 days after the date indicated above.)

A. Diagnosis and concurrent conditions(s):____

____

B. All dates of treatment in the last 60 days: ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

C. Is patient still under your care? Yes □ No □ If "No", please give discharge date: ____/____/____

D. Return to work estimate: Less than 6 months □ 6 to 12 months □ 12 to 24 months □ Never □
Actual date: ____/____/____

E. What physical or mental restrictions have you placed on this patient?__________________________

F. How many hours per week is the patient allowed to work with restrictions?____________________Hours per week.

G. Do restrictions still apply to this patient? Yes □ No □ Date restrictions ended:____/____/____

H. What period do you consider the patient to be totally and continuously disabled?
From: ____/____/____ To: ____/____/____

Physician's Comments:____

____

____/____/____	__________________________	____________________	______	(_____)_____-________
Date	Physician's Name (print)	Physician's Signature	Degree	Phone Number

______________________________	____________________	______	__________
Street Address	City or Town	State	Zip Code