GTL | GUARANTEE TRUST LIFE

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: _____/_____/_____

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## 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