DISABILITY
LIFE INSURANCE
CLAIM FORM

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607-723-3551 • www.smlny.com

Security Mutual... Your Partner for Life.℠

INSURED'S STATEMENT

IMPORTANT: *This form is to be completed by you and your attending physician and returned to the Home Office as soon as possible.*

Name		Date of birth	Policy number
Social Security Number		Residence address Zip Code	
Employer	Business address		Occupation
Date of sickness or accident		Date stopped work	☐ A.M. ☐ P.M.
Nature of sickness or injuries			
If injury; how and where did accident happen?			
Have you had the same or similar sickness or injury before? Give dates and details			
Name of physicians	Address		Date of first treatment
Name of hospital	Address		Admitted Discharged
Date you first resumed any duties	If not resumed, when do you expect to?		
If still disabled, describe present activities			
What other disability insurance do you have? Names of companies			Amount

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person who has attended me or has any records or knowledge of me or my health to furnish to Security Mutual Life Insurance Company of New York, or its representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Date Signed

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ATTENDING PHYSICIAN'S STATEMENT

Patient's name		Age
Nature of sickness or injury (Describe complications, if any)		
When did symptoms first appear or accident happen?	Date	
When did patient first consult you for this condition?	Date	
Has patient ever had same or similar condition?	☐ Yes ☐ No	
(If "Yes" state when and describe)		
Nature of surgical procedure, if any (Describe fully)		
Give dates of treatment.	Office Home Hospital	
If patient hospitalized, give name and address of hospital.	Admitted	Discharged
How long was or will patient be continuously totally disabled? (Unable to work)	From	Through
Remarks		

Date	Signed	
Street address	City or town	State Zip Code

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EMPLOYER'S STATEMENT

Employee's name	Date employed	Occupation	Policy number

Social Security Number	Date of birth

Base annual compensation (exclusive of bonuses, overtime, etc.)	Date last worked

Reason for leaving

☐ Disability ☐ Lay Off ☐ Dismissed
☐ Quit ☐ Leave ☐ Retired

Date returned to work	If not, expected date

Is employee entitled to Workers' Compensation for this disability? ☐ Yes ☐ No

Effective date of employee's or dependent's insurance	Amount of insurance	Classification	Date of termination of insurance

Date	Signed	Title

Name of firm	Business address

PLAN ADMINISTRATOR'S STATEMENT

Effective date of employee's or dependent's insurance	Classification	Date of termination of insurance

Date	Signed	Title