



Transamerica Worksite Marketing  
 P.O. Box 8043  
 Little Rock, AR 72203-8043  
 1-800-251-7254  
 7 a.m. – 5 p.m. CST

Transamerica Occidental Life Insurance Company  
 Transamerica Assurance Company  
 Transamerica Life Insurance Company  
 Monumental Life Insurance Company  
 Life Investors Insurance Company of America  
**Members of the AEGON Insurance Group**

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

**FRAUD STATEMENT**

Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and civil penalties.

**CLAIM FILING INSTRUCTIONS FOR DISABILITY BENEFITS**

1. Complete the **Statement of Insured** section on the front side of this form, answering all questions in full.
2. Have your employer complete the **Statement of Employer** section on the back of this form, answering all questions in full.
3. Have your physician complete the **Attending Physician's Statement** on the back of this form, answering all questions in full.
4. Fax or mail both sides of the completed form. FAX: 1-501-227-1651

**STATEMENT OF INSURED**

1. Name: \_\_\_\_\_ Certificate #: \_\_\_\_\_
2. Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
3. Mailing Address: \_\_\_\_\_ Is this a new address?
4. Date accident or illness began \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year
5. Nature of illness or injury: \_\_\_\_\_
6. If accident, where and how did it happen? \_\_\_\_\_
7. When have you had this same or similar condition? \_\_\_\_\_
8. Have you been confined to a hospital for this condition?  Yes  No  
 If Yes, Admitted: \_\_\_\_\_ Discharged: \_\_\_\_\_
9. Name and address of hospital(s): \_\_\_\_\_  
 \_\_\_\_\_
10. Name and address of doctor(s): \_\_\_\_\_  
 \_\_\_\_\_
11. Last date worked \_\_\_\_\_
12. On what date did you return to work? Part time \_\_\_\_\_ Full Time \_\_\_\_\_
13. If you have not returned to work, date you anticipate returning to work? \_\_\_\_\_
14. Identify any other sources and amount of income for which you are receiving or for which you may be eligible. This listing should include any other Group Disability Income Coverage, Social Security Benefits, Group Pension Benefits, Worker's Compensation, Salary Continuance, Veteran's Administration Benefits, any retirement, etc.

Your Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Effective Mo. _____	V.A. Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Effective Mo. _____
Dependent, Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Mo. _____	Railroad Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Mo. _____
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Mo. _____	Other Disability Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Mo. _____
Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Mo. _____	Other (Identify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	Mo. _____

**AUTHORIZATION**

LIFE INVESTORS INSURANCE COMPANY OF AMERICA	MONUMENTAL LIFE INSURANCE COMPANY	TRANSAMERICA LIFE INSURANCE COMPANY	TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY	TRANSAMERICA ASSURANCE COMPANY
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I certify that the above statements are true and correct to the best of my knowledge. I authorize any physician, practitioner or any hospital (including Veteran's Administration or governmental medical facility), clinic or other medical or medically related facility, any medical service organization, any insurance company, worker's compensation carrier, Social Security Office or any other institution or organization to provide the Company or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, any medical or other information, requested by it, including information relating to mental illness, use of drugs or use of alcohol concerning this or other illness or injury, so that the same may be included as part of the proof submitted to the Company. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be as valid as the original. This authorization is valid from the date signed for the duration of the claim. I understand that I, or any authorized representative, will receive a copy of this authorization upon request.

Date: \_\_\_\_\_ Signature of Insured: \_\_\_\_\_

**EMPLOYER'S STATEMENT**

Company Name		Address		Phone # ( )	
Name of Employee		Does this employee contribute to Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Was employee covered by the previous carrier? _____ Effective date: _____		If No, was the employee hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Benefit amount: _____		The percentage of the employee's Disability Premium you pay _____%			
Employee's Title: _____		Annual Salary: _____			
Is this loss a result of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has the employee made claim for or is he/she entitled to Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date employee last worked?			Date returned to work?		
Give final date of paid sick leave to which employee is entitled: (Indicate type: PTO, EIB, etc.)			<input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time		
			If Part time, due to Partial Disability, give weekly earnings: \$		
At the time of disability was the employee <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> On-Leave <input type="checkbox"/> Retired <input type="checkbox"/> No Longer Employed (Check one)?					
Is employee eligible for any other paid compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain what type of benefit this is:					
Monthly Benefit Amount: _____			Period eligible: _____		
Signature of Employer Representative			Title		Date

**ATTENDING PHYSICIAN'S STATEMENT**

Patient Name		Account #		SS #	
1. Diagnosis and concurrent condition				ICDA Code	
2. Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			3. Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the expected delivery date?		
4. Dates of services since disability commenced _____ _____			5. Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Hospital? _____ Address: _____ Admitted _____ Discharged _____		
6. Date symptoms first appeared or accident happened?			7. Date patient first consulted you for this condition?		
8. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and describe:			9. Is patient still under your care for this condition <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Patient was totally disabled (unable to work)? From _____ To _____			11. Patient was partially disabled? From _____ To _____		
12. If still disabled, date patient should be able to return to work			13. Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the referring physicians name & address?		
Date	Physician's Name – Print		Signature		Degree
				Phone # ( )	
Street address		City	State	Zip	Tax Identification #