

**ILLINOIS
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION**



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ILClaims@illinoisga.org*

POLICY #: _____

CLAIM #: _____

REPORT OF CONTINUED DISABILITY

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM, THE COMPANY SHALL NOT BE HELD
TO ADMIT VALIDITY OF ANY CLAIM OR TO WAIVE ANY OF ITS RIGHTS OR ANY OF THE CONDITIONS OF THE POLICY

CLAIMANT'S REPORT

NAME	ADDRESS		
CITY	STATE	ZIP	PHONE#

- What is the nature of your disability? _____
- What is your present health condition? _____
- State between what dates, if any, you were

Confined to a hospital.....	From _____	To _____
Confined to the house.....	From _____	To _____
Not house confined, but unable to work	From _____	To _____
- Date you resumed part of your normal duties? _____
- Date you resumed your full duties? _____
- If still disabled, when will you be able to resume

A portion of your duties? _____
All of your duties? _____
- Dates of medical attention since last report? _____

DATE _____ **SIGNED** _____

PHYSICIAN'S SUPPLEMENTARY REPORT

Patient's Name _____

- Cause of the disability? _____
What complications, if any, have arisen? (Describe fully) _____

- | | |
|------------------------------------|--|
| 2. Give dates patient was first: | Disabled? _____ |
| | House confined? _____ |
| | Able to leave the house? _____ |
| | Able to resume partial duties? _____ |
| 3. Give dates patient was treated: | At Home? _____ |
| | At the Office? _____ |
| | At the Hospital? _____ |
| 4. If still disabled is patient: | Now House confined? _____ |
| | Able to be out of doors? _____ |
| | Back to partial work? _____ |
| | Soon to resume part of his/her duties? _____ When? _____ |
| | Receiving regular treatments? _____ If so what? _____ |

Date _____ Signed _____ MD _____

Street _____ City _____ State _____ Zip _____

REMARKS OR SPECIAL FACTS _____