

Statement of Health

CLAIM NUMBER
_____ - _____ - _____ - _____

TO BE COMPLETED BY MEMBER

INSURED EMPLOYEE'S NAME	INSURED EMPLOYEE'S SOCIAL SECURITY NUMBER
INSURED EMPLOYEE'S STREET ADDRESS	CITY STATE ZIP CODE
NAME OF EMPLOYER (GROUP POLICYHOLDER)	GROUP POLICY NUMBER

TO BE COMPLETED BY PHYSICIAN

NAME OF DEPENDENT	SEX	DATE OF BIRTH	NATURE OF DISABILITY	DATES OF TOTAL DISABILITY
				FROM TO
				FROM TO
				FROM TO
				FROM TO
				FROM TO
				FROM TO
				FROM TO

PHYSICIAN'S NAME	PHYSICIAN'S TELEPHONE NUMBER
PHYSICIAN'S STREET ADDRESS	CITY STATE ZIP CODE
PHYSICIAN'S SOCIAL SECURITY NUMBER	PHYSICIAN'S EMPLOYER I.D. NUMBER
SIGNATURE OF PHYSICIAN	

MEMBER SIGNATURE

I hereby authorize my insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I certify that the information by me is support of this claim is true and correct. A copy of this authorization shall be valid.

_____ Signature of Insured Person _____ Date

PLEASE RETURN TO: ATTN: _____
 EMPLOYEE BENEFIT SERVICES
 PO BOX 82669, LINCOLN, NE 68501-2669 or fax to: 800-659-2223