ILLINOIS MUTUAL®
Life Insurance Company

300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Attending Physician's Supplementary Statement Accident Or Sickness

Claim No.

This form should be completed on or about (date) ______________________, or at the end of total disability, whichever first occurs, and returned to the Home Office as promptly as possible so any additional benefits due may be paid. Early completion may result in the form being returned or partial payment of benefits.

1. PATIENT'S NAME

2a. DIAGNOSIS (INCLUDING COMPLICATIONS AND OTHER DISEASE OR DISORDER AFFECTING PRESENT CONDITION)

2b. DATE OF YOUR LAST EXAMINATION ___/___/___ MO. DAY YR.

2c. OBJECTIVE FINDINGS

2d. SUBJECTIVE FINDINGS

3. HAS ANY SURGERY OR DIAGNOSTIC TESTING BEEN PLANNED OR PERFORMED? ☐ YES ☐ NO IF "YES," PLEASE PROVIDE DETAILS

4. DATES OF TREATMENT AND HOSPITALIZATION SINCE LAST REPORT OFFICE HOSPITAL

5. NAMES AND ADDRESSES OF OTHER DOCTORS WHO HAVE ATTENDED THIS PATIENT SINCE LAST REPORT

PROGRESS and PROGNOSIS

6a. PATIENT'S STATUS . . . ☐ RECOVERED ☐ IMPROVED ☐ REGRESSED ☐ UNCHANGED

6b. IS PATIENT CURRENTLY TOTALLY DISABLED BECAUSE OF INABILITY TO PERFORM MOST IMPORTANT DUTIES OF:
PATIENT'S JOB? ☐ YES ☐ NO ANY JOB? ☐ YES ☐ NO

6c. IS PATIENT CURRENTLY PARTIALLY DISABLED BECAUSE OF INABILITY TO PERFORM ONE OR MORE IMPORTANT DUTIES OF:
PATIENT'S JOB? ☐ YES ☐ NO ANY JOB? ☐ YES ☐ NO

6d. WHAT DUTIES OF PATIENT'S JOB IS HE/SHE UNABLE TO PERFORM?

6e. HOW LONG WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED AS INDICATED IN 6b. ABOVE? FROM ___/___/___ MO. DAY YR. THROUGH ___/___/___ MO. DAY YR.

6f. HOW LONG WILL PATIENT BE PARTIALLY DISABLED AS INDICATED IN 6c. ABOVE? FROM ___/___/___ MO. DAY YR. THROUGH ___/___/___ MO. DAY YR.

7a. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

7b. IF "YES", DATE OF NEXT APPT. ___/___/___
IF "NO", DATE OF DISCHARGE ___/___/___

8. IF REFERRED TO ANOTHER DOCTOR PROVIDE NAME/ADDRESS

9. REMARKS

10. PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT): ______________________

11. PHYSICIAN'S ID NUMBER ______________________ PHONE NUMBER (______) ______________________

12. PHYSICIAN'S SIGNATURE ______________________ DATE ______________________

IMPORTANT NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree. Florida Statutes, Sec. 817.234.