ILLINOIS MUTUAL®
Life Insurance Company

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

Claimant's Continuance of Disability Report
Accident or Sickness

This form should be completed on or about ______________________, 20 ______, 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. NOTE: Early completion may result in the form being returned or partial payment of benefits.

1a.	CLAIMANT'S NAME	1b.	PHONE (AREA)	1c.	CLAIM NO.
1d.	ADDRESS STREET CITY STATE ZIP				
2a.	DATES OF TREATMENT AND HOSPITALIZATION SINCE LAST REPORT OFFICE HOSPITAL				
2b.	NAME OF HOSPITAL	2c.	ADDRESS		
3.	NAMES AND ADDRESSES OF OTHER DOCTORS WHO HAVE ATTENDED YOU SINCE LAST REPORT				
4.	HAS ANY SURGERY OR DIAGNOSTIC TESTING BEEN PLANNED OR PERFORMED? IF SO, PLEASE PROVIDE DETAILS				
5.	WHAT ARE YOUR ACTIVITIES AND HOW DO YOU SPEND YOUR TIME?				
6.	DESCRIBE ANY CHANGES IN YOUR CONDITION AND INDICATE YOUR STATUS ☐ IMPROVED ☐ REGRESSED ☐ UNCHANGED				
7a.	DATE YOU RESUMED FULL-TIME DUTIES ___/___/___ (MO. DAY YR.) OR DATE YOU RESUMED PART-TIME DUTIES ___/___/___ (MO. DAY YR.)				
7b.	INDICATE DUTIES RESUMED				
8.	WHAT DUTIES OF YOUR JOB ARE YOU UNABLE TO PERFORM?				
9a.	DATE OF NEXT APPOINTMENT	9b.	NAME AND ADDRESS OF PHYSICIAN TO BE SEEN		

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.

Date ______________________, 20_____ X ______________________________
Signature of Claimant (Patient)