Mail This Form To:

Claims Department

OHIO NATIONAL LIFE

P.O. Box 237 - Cincinnati, Ohio 45201

1-877-446-3010

CLAIMANT'S CONTINUANCE OF DISABILITY STATEMENT
ACCIDENT OR SICKNESS CLAIM

IMPORTANT: ADDITIONAL PAYMENTS CANNOT BE MADE UNTIL THIS FORM AND THE ATTENDING PHYSICIAN'S STATEMENT (IF REQUESTED) HAVE BEEN RETURNED. ALL QUESTIONS MUST BE ANSWERED.

Print or type your name and address here and sign the form at the bottom

Name: _____ Policy No.: _____

Address: _____
Street City State Zip

Home Telephone No.: _____ Business Telephone No.: _____

1. What is causing your disability?

_____

2. Any change in your activities since the last report? ☐ Yes ☐ No, If yes, please provide details:

_____

3. Describe your daily activities, hobbies, work, etc.:

_____

4. Do you know when you will be returning to work? ☐ Yes ☐ No; If yes, please provide details:

Date: ☐ Full-Time ☐ Part-Time

5. If you have returned to work, please provide the following:

Name of Employer: _____

Address: _____
Street City State Zip

Date of return: _____ Duties: _____ Hours per week: _____

6. If you are partially disabled, please provide the dates: From: _____ Through: _____

7. If partial disability has not ended, when do you expect it to end? Date: _____

8. Is this your final claim as a result of this accident or sickness? ☐ Yes ☐ No

9. Are you now eligible for, have you applied for or are you now receiving income benefits from:

YES	NO		YES	NO	
☐	☐	Social Security	☐	☐	Unemployment Compensation
☐	☐	Workman's Compensation	☐	☐	State Cash Sickness Plan (UCD, TDB, DBL)
☐	☐	Pension Disability			
☐	☐	Any other disability income from any other company or organization e.g. (Federal, State, VA, Group, etc.)			

If answer is "Yes" to any of the above, please give details including amounts received, effective date, and the name of company, organization, or government agency from which benefits are being received.

Company/Organization	Amount Received	Address

10. IF YOU ARE CLAIMING RESIDUAL DISABILITY, PLEASE COMPLETE THE FOLLOWING FOR THE LAST CALENDAR MONTH:

_____ $ _____ $ _____
Month/Year Gross Revenue Net Income

The above statements are true and complete to the best of my knowledge and belief. The Laws of some states require us to furnish you with the following notice:

"Any person who knowingly and with the intent to defraud any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime."

AUTHORIZATION FOR RELEASE OF INFORMATION

PERSONS OR INSTITUTIONS: This authorizes you to give The Ohio National Life Insurance Company, its subsidiaries and representatives who are employed to assist in the evaluation of my claim any information, data or records you may have regarding me, my employment or my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may now have or have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by Ohio National to assist with this purpose. This authorization is valid during the pendency of my claim. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photostatic copy of this form will be as valid as the original.

Date: _____ Signature of Individual: _____

ATTENDING PHYSICIAN'S PROGRESS STATEMENT

This section to be completed only by Attending Physician or staff,
and is to be completed without expense to this Company.

PLEASE PRINT ALL ENTRIES AND RESPOND TO ALL QUESTIONS.

1. Patient's Name (last, first, middle) | 2. Diagnosis/Condition causing current impairment

3. Subjective symptoms limiting patient:

4. Objective Findings (including ECG's, lab data, other tests):

5. Date of last visit: | Date of next visit:

6. What restrictions or limitations if any, exist on your patient's ability to perform the duties of his/her occupation? (Please be specific)

7. When do you expect that these restrictions/limitations will change or end?

8. Nature of treatment (include consultations, surgery, medications - with dosages, radiation or physical therapy)

9. Since your last report:
   a) Patient has ☐ recovered ☐ improved ☐ remained unchanged ☐ regressed
   b) Patient is now ☐ ambulatory ☐ bed confined ☐ house confined ☐ hospital confined
   c) Has patient been hospitalized? ☐ Yes ☐ No; If "YES" where and when?

10. Physical Impairment (as defined in Federal Dictionary of Occupational Titles):
   ☐ Very Heavy Work: can lift over 100 lbs. with frequent lifting and/or carry objects of at least 50 lbs.
   ☐ Heavy Work: can lift a maximum of 100 lbs. and/or carry objects up to 50 lbs.
   ☐ Medium Work: can lift 50 lbs. maximum with frequent lifting and/or carrying up to 25 lbs.
   ☐ Light Work: can lift 20 lbs. maximum with frequent lifting and/or carrying up to 10 lbs.
   ☐ Sedentary Work: can lift 10 lbs. maximum and occasionally lift and/or carry such objects as dockets, ledgers, small books.

11. Cardiac Status (if applicable):

Functional Classification	*Therapeutic Classification (Activity)*
☐ Class I No limitation	☐ No restriction
☐ Class II Slight limitation	☐ Slight restriction
☐ Class III Marked limitation	☐ Moderate restriction
☐ Class IV Complete limitation	☐ Marked restriction
☐ Last blood pressure reading: Systolic: /Diastolic:	☐ Complete restriction

12. DSM III AXIS V adaptive functioning currently (if applicable):

☐ Level 1 Superior	☐ Level 5 Poor
☐ Level 2 Very Good	☐ Level 6 Very Poor
☐ Level 3 Good	☐ Level 7 Grossly Impaired
☐ Level 4 Fair	☐ Level 0 No Information

13. Is this patient a suitable candidate for rehabilitation? ☐ Yes ☐ No If "YES", what would you suggest?

14. Is the patient under the care of any other practitioner or therapist? ☐ Yes ☐ No If "YES", please complete the following:

Name:	Street Address		Name	Street Address	
City	State	Zip	City	State	Zip

15. Remarks:

Name (Attending Physician) Please Print | Degree Specialty | Telephone Number

Street Address | City or Town | State or Province | Zip Code or Postal Code

Signature of Attending Physician | Date

Form 9133 Rev. 4/04

INSURED _____ POLICY NUMBER _____

INSURED'S STATEMENT OF EARNINGS

MONTH ENDING _____

Please report your earnings for the month, using the worksheet below.

Note: EARNINGS as defined in your contract means:

Any money you receive in any business, occupation or profession. It includes salary, wages, bonuses, commissions, fees and income from self employment. It does not include:

- business expenses deductible from gross income for federal tax purposes;
- income from a pension, profit sharing or deferred compensation plan; or
- dividends, interest or royalties
- rent or other investment income, unless this is the principal source of earnings prior to disability.

EARNINGS:

- includes only money you receive for work done after the start of your disability
- does not include money received during your disability for work done prior to the start of your disability.

WORKSHEET

Attach financial documentation, i.e. insured's payroll check stubs, employee earnings record and monthly business income statements.

	Salary		_____	a)
+	Pension Contribution	+	_____	b)
+	Other Compensation	-	_____	c)

If owner, partner or shareholder, complete business income calculation:

	Business Income (Loss)		_____		
-	Collections on Work Performed by Insured prior to Disability	-	_____		
=	Net Business Income (Loss)	=	_____		
x	Percentage Ownership	x	_____		
=	Insured's Share Income (Loss)	=	_____	⇨ _____	d)
=	Total Post Disability Earnings			= _____ Sum a) to d)	

I certify to the best of my knowledge and belief that the above is a true, correct and complete statement of my net earned income for the month specified.

The following notice is required for compliance with laws of various states:
"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

Insured's Signature: _____ Date: _____