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#

1. What is the nature of your disability? _____
2. What is your present health condition?

3. 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

4. Date you resumed part of your normal duties? _____
5. Date you resumed your full duties?

6. If still disabled, when will you be able to resume	A portion of your duties?	
	All of your duties?	

7. Dates of medical attention since last report?

DATE _____ **SIGNED** _____

PHYSICIAN'S SUPPLEMENTARY REPORT

Patient's Name _____

1. 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?		
	Able to resume full 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 _____