PEKIN LIFE INSURANCE COMPANY
2505 Court Street Pekin, Illinois 61558

STATEMENT OF CLAIMS

All sections must be completed or form will be returned. Once completed in full, this form can be folded and mailed in the enclosed envelope. Please be sure the return address printed on the reverse of this form is placed in the window portion of the return envelope.

Policy _____

Insured's Name	Patient's Name	Patient's Date of Birth

Address	Telephone Number	Social Security Number

Is patient covered by any other insurance? _____ yes _____ no

If yes: Name & phone number of the other company _____

Type of Coverage _____ Effective Date _____

Policy No. _____ Social Security No. of Policy Holder _____

Please indicate what this treatment was for (Describe sickness or how injury occurred) _____

_____

Date symptoms began or injury occurred _____

Date first treated _____

Name & address of first doctor seen for this condition _____

Have you ever had a similar condition? _____ yes _____ no

If yes, prior doctor's name & address _____

Family doctor's name & address _____

Is this condition covered by a Worker's Compensation policy? _____ yes _____ no

Has a claim been filed with them? _____ yes _____ no Name of Employer _____

AUTHORIZATION

PEKIN LIFE INSURANCE COMPANY or its representatives are hereby authorized to examine and secure copies of any medical records, including information relating to mental illness, and drug and alcohol use, employment records, governmental records, records of other insurance companies, or other records or information. A copy of this authorization shall be considered as valid as the original.

I understand that such information will be used by Pekin Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I or any authorized representative will receive a copy of this authorization upon request.

This authorization is valid for the date signed for the duration of the claim.

DATE _____ **SIGNED** _____

(If Patient/Employee is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. If Patient/Employee is deceased, Personal Representative or Next of Kin must sign.)

Indiana Policyholders: Submission of a false insurance claim with intent to defraud an insurer is a Class D felony.

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PEKIN LIFE INSURANCE
PO Box 1587
Pekin, Illinois 61555-1587