

Underwritten by:



UPDATE FORM TEMPORARY DISABILITY INCOME

IMPORTANT READ CAREFULLY

1. You and your physician must complete and sign the appropriate sections of this form.
2. Return to us by: _____ to avoid interruption of your disability income benefits.

Return Form To:
Benefit Services of Hawaii, Inc.
P.O. Box 840
Honolulu, HI 96808-0840
Telephone (808) 538-8900
Toll Free (800) 490-3956
Fax (808) 538-8930

CLAIMANT INFORMATION

Please PRINT and complete all information. Incomplete answers may cause delay.

Claimant's Name (First, middle, last)	Social Security No.	Claim Number
Claimant's Address (Street, City or Town, State, Zip Code)	Home or Other Telephone No.	
Employer's Name		

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date: _____ Signature of Insured: _____

ATTENDING PHYSICIAN'S STATEMENT

Please answer all questions.

Diagnosis & Concurrent Conditions:	ICD Code (must have to process claim):	If pregnancy, advise delivery date:
How long was or will patient be unable to work? From _____ Through _____		
Date patient can return to work: _____		
Dates of Treatment:		
Date of first visit _____	Date of last visit _____	
Frequency of visits _____	Date of next appointment _____	
Nature of Treatment (Include surgery, medications, etc.):		
Current Restrictions and Limitations:		
Describe any circumstances causing disability to be prolonged:		
Physician's Signature	Date	
Physician's Name	Degree	
Address	Telephone ()	
City	State	ZIP

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida

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 the third degree.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Retain for your records.