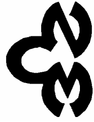


NORTH CAROLINA MUTUAL
LIFE INSURANCE COMPANY

Type of Claim (Check Applicable Box)

Permanent Total Disability ☐
Waiver of Premium ☐
Long Term Disability ☐

Group Disability Claim Form

THIS STATEMENT IS TO BE COMPLETED PROMPTLY TO AVOID DELAY.
BE SURE ALL QUESTIONS ARE ANSWERED FULLY.

Return to: NCM Life Insurance Co.
Group Life Claims Team
411 West Chapel Hill Street
Durham, NC 27701
Attn: Sharon Lee

STATEMENT OF EMPLOYER OR TRUSTEE

Name of Group	Policy Number	
Effective date of Insurance	Cancellation Date (if applicable)	Certificate Number (if applicable)
Duration of Employment From: To:	Date Last Worked	Date Eligible for Benefits
Amount of Insurance $	Monthly Salary $	Beneficiary Designations

Is Insured receiving any other weekly or monthly disability benefits? If "yes", give details-source of benefits – amount – date benefits began or will begin.

Are there any reasons for you to question the validity of the claim? If so, give particulars

Signature of Trustee of Employer Representative	Date	Telephone Number

STATEMENT OF COVERED EMPLOYEE OR MEMBER

Last Name First M.I.	Date of Birth	Social Security Number	Telephone Number

Present Address	City	State	Zip Code

1. Describe Fully the Daily Duties of Your Job:

2. Date When You Last Reported for Work	3. Date When You Expect to Return FT: PT:	4. Date of First Medical Treatment for this Disability

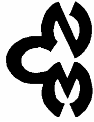
5. Are you now engaged in the duties of any occupation or endeavor for wages, profit or compensation?
☐Yes ☐ No Explain:

6. Was an accident involved? ☐Yes ☐ No Were you at work when it happened? ☐Yes ☐ No

7. What physicians have treated or prescribed for you this sickness or injury?
(Names) (Addresses) (Names & Addresses of Hospitals confined to during this disability)

8. Are you receiving any benefits as a result of your disability? ☐Yes ☐ No If "yes", check applicable boxes & complete requested information:

			Amount	(Date benefit began, or will begin)
☐Yes	☐ No	A. Primary Social Security		
☐Yes	☐ No	B. Family Social Security		
☐Yes	☐ No	C. Worker's Compensation		
☐Yes	☐ No	D. Pension Plan		
☐Yes	☐ No	E. Federal State, Municipal or other Government Agencies		



NORTH CAROLINA MUTUAL
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9. If you are not receiving benefits from any of the above mentioned sources, have you filed or do you intend to file for such benefits? Give complete details below.

10. Birthdate of all dependent children (dependent children are (1) all children under age 18, (2) full-time students under age 22 and (3) handicapped children regardless of age if disability began before age 18.):

11. Spouse's Date of Birth ________________

12. List name and addresses of all other companies providing disability benefits.

I hereby make claim for benefits and certify that the above statements are true and complete to the best of my knowledge and belief. I authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to the North Carolina Mutual Life Insurance Company any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be valid as the original.

Dated _________________ 20_____ Signed ____

ADDITIONAL COMMENTS:

Please sign and date if you have made additional comments:

Claimant's signature	Date
Physician's signature	Date