Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8417

IMPORTANT READ CAREFULLY

1. **This form must be signed by you and completed and signed by your physician.**
2. **Return to us by: ____________________________ to avoid interruption of your weekly disabilty income benefits.**

UPDATE FORM
SHORT TERM DISABILITY

	Claim Number:
	Employer:
	Home or Other Daytime Phone Number:

Authorization to Obtain Information

I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (or its representatives) and to permit them to examine and copy such information. I understand that USAble Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with the underwriting or claims processing with the company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

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:**	**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**