WINDSOR LIFE
INSURANCE COMPANY
1345 River Bend Drive Dallas, Texas 75247 fax 214-528-2777

APPLICATION FOR GROUP CRITICAL ILLNESS BENEFIT CLAIM

CLAIMANT'S STATEMENT

1. PERSONAL INFORMATION

Group Policy Number _____

Name of Insured: _____ Date of Birth: _____
Last Name First Name M.I.

Telephone Number: _____ Social Security No.: _____

Address: _____

_____

2. DETAILS OF CRITICAL ILLNESS:

a) Describe your disease or condition: _____

_____

_____

Date of diagnosis: _____

b) When did the first symptoms appear?
Month Day Year

_____

c) When did you first consult a physician for this disease or condition? _____

_____

Name & address of that attending physician: _____

_____

d) Provide details and dates of tests or exams to confirm the diagnosis: _____

_____

_____

e) Describe current and past treatments for this disease or condition:
Type of treatment Hospital / Institution / Treating Physician Dates

_____

_____

_____

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f) Have you previously suffered from or received treatment for the same or a similar disease or condition? If yes, provide details and dates: _____

_____

_____

3. MEDICAL CONSULTATIONS

a) Name and address of your personal physician: _____

_____

b) Names, addresses and dates seen by any other physicians or specialists for this disease or condition: _____

_____

_____

_____

c) Names and address of any hospital or other medical facility admitted to or discharged from concerning this disease or condition, to include the dates: _____

_____

_____

_____

I hereby give permission to any physician, medical practitioner, hospital, medical facility, insurance or reinsurance companies to release, upon presentation of the original or a photocopy of this signed and dated authorization, requested information to **Windsor Life Insurance Company** or its representative (specifically the Claims Department, Medical Director, Legal Department, or Investigative Agency) in connection with any disease, treatment, prior medical history or prescription. This authorization includes information relating to medical illness, use of drugs, and use of alcohol. I understand that such information will be used by **Windsor Life Insurance Company** for the purpose of evaluation of my claim for insurance benefits, and I wish this authorization to be effective from the date signed for the duration of the claim.

Date_____ Signature of Insured _____