KSKJ LIFE
2439 GLENWOOD AVE. JOLIET, IL 60435
1.800.843.5755 kskjlife.com

Claim No. _____

Local Representative Address

SURGICAL AND PERMANENT DISABILITY CLAIM

(Limited Certificate—Benefits based on predetermined schedule)

Full Name of Insured _____ Certificate No. _____ Lodge No. _____

Residence Address _____

Last 4 Digits of Social Security No. ____ ____ ____ ____ Age _____ Surgical Schedule F5A

AUTHORIZATION

I hereby authorize the hospital or physician who has attended above claimant to release any and all information regarding the illness or accident. Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or filed a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature _____ _____ _____
Insured/Owner/Claimant | Date | (Area Code) / Phone Number

Physician's or Surgeon's Report

NOTE: Signed Standard Insurance Claim forms, giving necessary information, are acceptable in lieu of this form. Please attach to back of this form.

1. Claimant's Name _____ Age _____
2. Occupation at time of disability _____ Date first disabled _____
3. Date first seen by you or any other physician for this ailment _____
4. Detailed description of disability: _____
5. Name of operation, if any: _____
6. Date of operation _____
7. Name of facility where operation was performed _____
8. If **loss of vision**, is loss permanent? ☐ Yes ☐ No Percent Loss: _____% Right Eye _____% Left Eye
9. If **loss of use of limbs**, is same total and permanent? ☐ Yes ☐ No Which limb(s)? _____
   Was any limb amputated? ☐ Yes ☐ No If yes, which limb(s)? _____
10. Further information which might help in properly understanding the claimant's condition: _____

Attending Physician Name _____ Physician/Clinic Phone No. _____

Physician/Clinic Name _____

Physician/Clinic Address _____

Physician Signature _____ Date _____

NOTE TO PHYSICIAN—RETURN CLAIM TO CLAIMANT, LOCAL REPRESENTATIVE OR KSKJ OFFICE.

HOME OFFICE USE ONLY:

APPROVED: No. _____ $ _____

DECLINED: _____

REMARKS: _____

DATE _____ _____
H/O Medical Consultant