

# Disability Continuance FORM

**ADVANCE**  
Insurance Company of Kansas  
1133 SW Topeka Blvd, Topeka, KS 66629-0001  
Phone (785) 273-9804 or Toll-free (800) 530-5989  
FAX (785) 273-6121 advanceinsurance.com  
Claim no. (for office use only)

**Notice:** No additional benefits will be paid until this claim form has been completed and returned to our office. This form will be returned to you if all questions are not answered completely.

## (to be completed by Physician's office only) Attending Physician's Statement

1. Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(Last) (First) (Middle) (MM-DD-YYYY)

2. Diagnosis (**Describe complications, if any**) \_\_\_\_\_ ICD 9 code \_\_\_\_\_  
a) If pregnancy, please provide the following: EDC \_\_\_\_\_ Delivery date \_\_\_\_\_ Type of delivery \_\_\_\_\_

3. Current treatment program prescribed (including surgery, medication, physiotherapy, etc.): \_\_\_\_\_ ICD 9 code \_\_\_\_\_  
\_\_\_\_\_

a) To your knowledge, is the patient following the recommended treatment program?  Yes  No

4. Dates of treatment:  
a) Date you **first** treated patient for this episode of disability: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_  
b) Date of most recent treatment: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_  
c) Frequency:  Weekly  Monthly  Other (specify): \_\_\_\_\_  
d) Date of next scheduled visit: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_

5. This patient has been continuously disabled (unable to work) from \_\_\_\_\_ through \_\_\_\_\_

6. If still disabled, when should patient be able to return to work? Part-time \_\_\_\_\_ Full-time \_\_\_\_\_  
or, this patient will recover in: \_\_\_\_\_ no. of weeks,  1 month,  2-3 months,  4-6 months, or \_\_\_\_\_ (state period)

7. Remarks: \_\_\_\_\_

Date \_\_\_\_\_ Physician sign here **X** \_\_\_\_\_  
Specialty \_\_\_\_\_ Physician's full name (please print) \_\_\_\_\_  
Full address \_\_\_\_\_  
(PO Box and Street, City, State and Zip)  
Phone no. ( ) \_\_\_\_\_ Fax no. ( ) \_\_\_\_\_

## (to be completed by the employee only) Employee's Statement

Your full name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
(Last) (First) (Middle)

Name of employer: \_\_\_\_\_

1. What other income are you receiving, or are eligible for, as a result of this disability? (PIP or Personal Injury Protection under auto insurance, other employer-sponsored/payroll-deducted disability policy, Social Security, Worker's Compensation, etc.)

Source of income	Amount of income	Date income began	Date income ended
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you returned to work?  Yes  No If yes, on what date did you return to work? \_\_\_\_\_

3. Are you presently able to return to work **part-time or full-time**?  Yes, part-time  Yes, full-time  No, cannot return to work  
If no, when do you expect to return to work? \_\_\_\_\_

4. Remarks \_\_\_\_\_

The above statements are true and complete to the best of my knowledge and belief. I understand the furnishing of this form and its acceptance by the Company shall not be construed as an acknowledgment of any liability nor a waiver of any rights on the part of the Company. I hereby authorize any hospital or physician who has treated me, other person who has attended me, examined me, or any government agency to furnish to Advance Insurance Company of Kansas (AICK) providing this form, or their representatives, any and all information with respect to any illness, injury, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this authorization will be as valid as the original. I may revoke this authorization by notifying AICK in writing of my desire to do so. This authorization expires two years from the date signed.

Date \_\_\_\_\_ Employee sign here **X** \_\_\_\_\_

### - Warning -

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. Report fraud to our Fraud Hotline (800) 530-5989.