

Medical History **FORM**



1133 SW Topeka Blvd, Topeka, KS 66629-0001
 Phone (785) 273-9804 or Toll-free (800) 530-5989
 FAX (785) 273-6121 advanceinsurance.com

To assist us in making medical inquiries regarding your claim, please submit the following data in reference to all medical care for the condition(s) for which you are claiming disability benefits.

Claimant Name:	Date of Birth:
----------------	----------------

Please tell us who provided medical services to you from _____ to _____.

I have consulted with the following doctors:

I have been treated or confined at the following Hospitals:

Name:			Hospital name:		
Specialty:			Dates treated or confined:		
Address:					
City:	State:	Zip:	City:	State:	Zip:
Phone #		Fax #:	Phone #		Fax #:

Name:			Hospital name:		
Specialty:			Dates treated or confined:		
Address:					
City:	State:	Zip:	City:	State:	Zip:
Phone #		Fax #:	Phone #		Fax #:

Name:			Hospital name:		
Specialty:			Dates treated or confined:		
Address:					
City:	State:	Zip:	City:	State:	Zip:
Phone #		Fax #:	Phone #		Fax #:

Name:			Hospital name:		
Specialty:			Dates treated or confined:		
Address:					
City:	State:	Zip:	City:	State:	Zip:
Phone #		Fax #:	Phone #		Fax #:

If additional space is needed, use the blank space on the second page of this form or attach a separate signed and dated listing.

