Medical History 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) 290-0727 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:		
Clinic Name:			Dates treated or confined:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone #	Fax #:		Phone #	Fax #:	

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

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

Name:			Hospital name:		
Clinic Name:			Dates treated or confined:		
Address:			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.

Claimant name:	Date of birth:

The following Prescriptions have been filled for treatment of my conditions. Please see the label on the RX Bottle to provide this information. If additional space is needed, use the blank space below or attach a separate signed and dated listing.

RX #	Name and address of Pharmacy	Dr. who prescribed	Drug name

Claimant sign here X_____ Date signed _____