# Disability Continuance FORM

ADVANCE Insurance Company of Kansas*
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Phone (785) 273-9804 or Toll-free (800) 530-5989
FAX (785) 290-0727 advanceinsurance.com

**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.

**Claim no. (for office use only)** _____

CLEAR DATA

(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? (including any form of employment) Or, are eligible for as a result of this disability? (Personal Injury Protection under auto insurance, other employer-sponsored/payroll-deducted disability policy, Social Security, Worker's Comp, 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.