INSURANCE MANAGEMENT SERVICES

P.O. Box 15688 • Amarillo, TX 79105

NAME OF EMPLOYEE _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____

I hereby authorize any hospital, physician, or other person who has attended or examined me to furnish Insurance Management Services any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authrization shall be considered valid.

Date _____ Employee's Signature _____

ATTENDING PHYSICIAN'S STATEMENT

PLEASE ANSWER ALL QUESTIONS FULLY. FORM SHOULD BE RETURNED TO PATIENT OR EMPLOYER PROMPTLY

Patient's Name _____

Nature of sickeness or injury (Describe complications, if any) _____

Is condition due to injury or sickness arising out of patient's employment ? Yes____ No_____

IF YES, EXPLAIN IN REMARKS BELOW

Date of first treatment _____

Date of most recent treatment _____

Frequency of treatments _____

The patient has been continuously disabled (unable to work) from _____ through _____

If still disabled, when should patient be able to return to work? (if uncertain, please estimate)_____20_____

Remarks _____

Date _____ Signed _____

Address Phone

STATEMENT OF EMPLOYER

Effective date of patient's coverage _____ Weekly Disability Class _____

If terminated show date _____

Is claim one which might be insured under any Workmen's Compensation or Occupational Disease Act? Yes _____ No _____

Date last worked _____ Date returned to work _____

(month) (Day) (Year)

Regular Weekly Wage _____ Weekly Benefit _____

Group Policy Number _____ Employer _____

Claim File No. _____ By _____

Date