GULF GUARANTY LIFE INSURANCE COMPANY

P.O. Box 12409 • Jackson, Mississippi 39236-2409

APPLICATION FOR CONTINUATION OF DISABILITY BENEFITS

This form must be completed every 30 days in order for the company to determine if disability benefits are to be continued. Any cost for the completion of this form must be borne by the insured.

– INSURED'S STATEMENT –

1. Name of Creditor _____ Certificate No. _____
2. Date Total disability Began _____
3. Date Partial Disability Began _____
4. Date Disability Terminated _____

The above answers are true and correct to he best of my knowledge. I hereby authorize any physician, surgeon, practitioner, or other person, any hospital (including veterans administration or government hospital), insurance company or any employer to release other information required, concerning this or other disabilities, to Gulf Guaranty Life Insurance Company. A photostat of this authorization shall be as valid as the original.

Insured's Signature _____ Date _____

Street Address _____ Phone _____

City _____ State _____ Zip _____

– EMPLOYER'S STATEMENT –

1. Name of Employee _____ Duties _____
2. Dates of 100% Total Disability: From _____ To _____
3. Give dates employee did any type of work in supervisory or any other capacity: _____

Employer's Signature _____ Date _____

Position _____ Phone _____

– ATTENDING PHYSICIAN'S STATEMENT –

Patient's Name _____ Age _____

1. Nature of sickness or injury: (Describe any complications) _____

_____

2. Give date of last treatment _____, 20 _____.
3. Give the date the patient was first unable to do any work due to total disability _____
4. As of the present time, do you consider this patient totally disabled from doing any work?

   Yes _____ No _____

   If yes, on what date do you believe the patient will be able to return to any type of work? _____

   If no, on what date was the patient first able to perform any type of work? _____
5. If hospitalized, give name of hospital and dates of confinement.

   Hospital _____ From _____ To _____

Date _____ Signed _____

Attending Physician

Address _____

_____