Insured Statement for Premium Waiver Due to Disability

1. Insured Information

Full Name

Date of Birth

Policy Number

Address

Phone Number

Email Address

2. Details of Disability

Date Disability Began

Nature of Disability

Diagnosis

Attending Physician's Name

3. Current Employment Status

Are you currently employed?

☐ Yes

☐ No

If not, last date worked

Occupation

4. Declaration

I hereby declare that the above information is true and complete to the best of my knowledge. I understand that any misrepresentation or concealment may result in the denial of my claim for a premium waiver.

_____

Signature of Insured

_____

Date

Note: Please attach supporting documents such as medical reports and submit this form to your insurance provider.