



The First Rehabilitation Life Insurance Company of America

600 Northern Boulevard, Great Neck, New York 11021-5202
(516) 829-8100 (800) 365-4999 Fax: (516) 829-8213
www.firstrehab.com

THIS FORM MUST BE COMPLETED AND RETURNED TO PROCESS YOUR CLAIM

CLAIM NO. _____

DATE _____

INSURED SUPPLEMENTARY STATEMENT

1. ARE YOU STILL TOTALLY UNABLE TO WORK ? _____

2. HAVE NOT BEEN EMPLOYED IN ANY WAY FOR COMPENSATION, GAIN OR PROFIT

DURING THE PERIOD _____ THROUGH _____

3. MY LAST VISIT TO THE DOCTOR WAS ON _____

4. I PLAN TO RETURN TO WORK ON _____

I hereby certify that the above statements are true, that they are made by me to induce **The First Rehabilitation Life Insurance Company of America** to allow disability benefits in accordance with the coverage of the insurance policy and/or certificate issued to me, and that I understand that no benefits are payable for a period during which I am gainfully employed, and that any disability benefits allowed to me by said insurer will be in reliance upon the truth of said statements.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date of report _____ Signature _____

Return This Completed Form to:

**First Rehabilitation Life - Claims Dept.
600 Northern Blvd.
Great Neck, New York 11021-5202**