PIONEER®
YOUR INSURANCE

INSURED'S STATEMENT OF DISABILITY

The Company makes no admission of liability or waiver of rights by furnishing this form.
This statement must be fully answered by the Insured or his/her duly appointed Guardian, if not capable.

Full Name of the Insured	Date of Birth	Occupation
Present Residence		

a. Cause of Disability ☐ Related to employment ☐ Injury ☐ Illness

b. Date and Place of Commencement of Disability

c. Describe fully your present condition and state how and to what extent you are unable to perform any occupation for remuneration or profit.

d. Describe briefly your daily activity/routine.

e. Occupation
i) Who is your present (or last) employer ______________________ Position held: ____________________
ii) When was the last date you were able to report to work? ________________________________

f. State the name and address of every physician or practitioner in attendance or consulted.

(Duration)		Name of Physicians or Practitioner	Address
From	To		

g. Have you done any kind of work since commencement of present disability? If so, state full particulars and dates.

h. When do you expect to work again?

i. Do you have any claim because of your illness or injury against any person or company? Give names and their addresses.

Authorization To Release Information:
I/We hereby authorize **Pioneer Life Inc.**, its reinsurers and/or its duly authorized representatives to collect, retrieve, use and/or otherwise process from any government or private hospitals, offices or any other personal information, controllers and processors who collects, holds, processes or uses any of my and the named insured's personal information, and for any of the latter to furnish Pioneer Life Inc., its reinsurers and/or its duly authorized representatives with, any personal information, sensitive personal information and privileged information, including copies (original or certified) of documents, relating to any of my and the named insured's personal information. This authorization is being made in connection with any claim on the insurance policy or policies issued by the insurance company on the life of the abovementioned Insured. It is understood that any action of any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controllers and processors who collects, holds, processes or uses any of my personal information may take in connection with this authorization releases said persons or entities or any and all members of their staff from any responsibility or obligation in connection with the release or processing of such records or information.

I/We hereby certify that I/We have carefully read and clearly understood the terms of the above said authorization, and do hereby voluntarily accept and acknowledge the same as an informed expression of my own free will.

PIONEER LIFE INC.
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NOTE: Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

I / We hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I / We understand and accept that in the event that this claim is found to be fraudulent in whole or in part, the Policy shall be void and all the rights to recover thereunder in respect of past or future claims shall be forfeited.

Signature over Printed Name	Date