

Pregnancy Disability Claim

For Claims Customer Service: For Claims Submission:	Phone:	` '	45708
me of patient: Date of Birth:			
Attending Physician St	atemen	(To be complete	ed by the physician)
for insurance or statement of c misleading, information conce	laim contai rning any fo	ning any materia act material there	nsurance company or other person files an application ly false informaiton, or conceals for the purpose of eto, commits a fraudulent insurance act, which is a eed five thousand dollars and the stated value of the
Date of patient's last menstrua	tion:	Date o	f 1st treatment for this pregnancy:
Please list any complications o	f pregnancy	y:	
If yes, what is the date of delivery Delivery Type: Vaginal	ined? Yes ary:	No□ If no, w and discharg If C-Section:	
			From: To:
Physician's Name: (please print): _			
Specialty:			
Address:			
Phone: ()	Fax: ()	
Signature:	al records rel	ating to the claim c	Date Signed: condition including treatment notes & test results. iii Address:
is encrypted. We strongly encourag	je you to use (encrypted email whe	you should be aware that outgoing email is not secure unless it en sending sensitive and/or confidential information. By sending

confidentiality. If you elect to communicate from your workplace computer, you also should be aware that your employer and its agents

have access to email communication between you and us.