



COTTON STATES LIFE INSURANCE COMPANY
 244 Perimeter Center Parkway N.E. Atlanta, Georgia 30346
 Mailing Address: P.O. Box 105303 Atlanta, Georgia 30348
 Toll Free: 1-800-457-1657

CLAIMANT'S STATEMENT OF DISABILITY

1. INSURED'S Name _____ Policy Number(s) _____
 Address _____ Date of Birth _____

2. EMPLOYER'S Name _____ Address _____

3. Disability Benefits In Force - Other Companies: (If none, state none.)

| COMPANY | DISABILITY WAIVER | DATE ISSUED | DISABILITY INCOME | DATE ISSUED |
|---------|-------------------|-------------|-------------------|-------------|
| _____ | \$ _____ | _____ | \$ _____ | _____ |

4. a. What is the diagnosis of the Insured's medical condition? _____

b. Date first diagnosed? _____ c. Date first disabled? _____

5. Is the Insured:

a. Confined to their home? ____ Yes ____ No b. Confined to bed? ____ Yes ____ No

c. Confined to a Medical Facility? ____ Yes ____ No If 'Yes', complete the following:

NAME OF FACILITY ADDRESS

6. List all physicians who have treated the Insured for this medical condition.

NAME OF PHYSICIAN ADDRESS DATE FIRST TREATED

7. a. What was the Insured's occupation at time of disability? _____

b. Date last worked? _____ c. Date resumed work? _____ d. Date expected to resume work? _____

8. Explain why this medical condition prevents the Insured from doing the substantial and material duties of his or her regular occupation. _____

FAIR CREDIT REPORTING ACT - PRE-NOTIFICATION FORM

Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this claim which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request, a complete and accurate disclosure of the "nature and scope" of the report, if one is made, will be provided.

AUTHORIZATION

I hereby certify that these answers are true and correct to the best of my knowledge. I understand that the completion of this form will not be construed as an admission by the Company of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract. I agree that any physician's statements, affidavits, or additional papers required by the Company will be made a part of this claim.

I authorize any medical professional, medical care institution, insurance institution, consumer reporting agency or similar institution, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or other organization having records or knowledge of me or any member of my family, to release to Cotton States Life Insurance Company, or its reinsurers, any and all such information it may require in the investigation of this claim. I certify that I have received notification regarding the Fair Credit Reporting Act, and understand that I may request a personal interview by a consumer reporting agency. I hereby waive all rights of confidentiality under state and federal credit privacy laws and release from liability the user as well as the person or firm providing such information. A photocopy of this authorization will be considered as effective and valid as the original.

Insured's Signature _____

Date _____

Owner's Signature _____

Date _____