CLAIMANT'S STATEMENT FOR CONTINUANCE OF DISABILITY BENEFITS

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY ● HOME OFFICE ● LOS ANGELES, CALIFORNIA 90054

(Waiver of Premium Benefits under Ordinary Policies)

NAME

POLICY NOS.

PRESENT ADDRESS *No. & Street* *City* *Zone* *State*

IF ABOVE ADDRESS IS WRONG, PLEASE WRITE CORRECT ADDRESS *No. & Street* *City* *Zone* *State*

IS THIS TO BE YOUR PERMANENT ADDRESS? ☐ YES ☐ NO

IF YOU ARE *NOT* PRESENTLY EMPLOYED, ARE YOU:

BED-CONFINED? ☐ YES ☐ NO HOUSE-CONFINED? ☐ YES ☐ NO

HOSPITAL-CONFINED? ☐ YES ☐ NO WHEEL CHAIR-CONFINED? ☐ YES ☐ NO

DO YOU BELIEVE YOUR HEALTH IS IMPROVING? ☐ YES ☐ NO

WHAT ARE YOUR PRESENT DAILY ACTIVITIES?

IN YOUR OPINION, ARE YOU ABLE TO DO SOME KIND OF WORK? ☐ YES ☐ NO

WHEN DO YOU THINK YOU MIGHT BE ABLE TO RETURN TO WORK?

HAVE YOU ATTEMPTED ANY EMPLOYMENT SINCE YOU BECAME DISABLED? ☐ YES ☐ NO

IF YES,

NAME OF EMPLOYER

EMPLOYER'S ADDRESS

DUTIES

FROM TO

IF *PRESENTLY* EMPLOYED, ON WHAT DATE DID YOU RESUME WORK?

☐ PART TIME? DATE ____________ ☐ FULL TIME? DATE ____________

FOR WHOM DO YOU WORK? *(Name and Address)*

WHAT ARE YOUR DUTIES?

DO YOU BELIEVE YOU CAN CONTINUE WITH YOUR WORK? ☐ YES ☐ NO

IF NOW WORKING *PART TIME*:

______ HOURS A DAY ______ DAYS A WEEK

TO BE COMPLETED BY *FEMALE* CLAIMANT ONLY

DO YOU PERFORM ANY HOUSEHOLD DUTIES? ☐ YES ☐ NO

IF "YES", DESCRIBE

DO YOU HAVE HELP WITH THE HOUSEHOLD DUTIES? ☐ YES ☐ NO

IF "YES", EXPLAIN

ADDITIONAL REMARKS:

____
(Claimant's Signature)

____
(Date)

C 3601/65