Fidelity Life Association: 877-352-3303
Administered by Selman & Company
One Integrity Parkway
Cleveland, OH 44143

CL 2.e

CLAIMANT'S STATEMENT OF DISABILITY

1. INSURED'S Name _____ Policy Number _____
   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. 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 condition.

NAME OF PHYSICIAN	ADDRESS	DATE FIRST TREATED

7. Is the Insured totally disabled? ____ YES ____ NO Date first disabled? _____ Date last worked?_____
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 Fidelity Life Association, 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 right 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