PERSONAL ACCIDENT INSURANCE
(Accident & Sickness & Disease Policy)

PROOF OF TEMPORARY TOTAL DISABLEMENT FORM

Issuance of this form does not imply admission of liability. The form must be filled out by the Insured. Further information may be required during the investigation of this submission.

Please answer all questions completely and return form, together with the executed authorization to obtain information and executed Attending Physicianôs Statement, to Pro Financial Services, LLC, 500 West Madison, Suite 2660, Chicago, Illinois 60661. Incomplete forms will be returned for completion. Please use extra sheets, if necessary.

Covered Individual: _____

Covered Individualôs Address: _____

Covered Individualôs Telephone Number: _____

Profession: _____

Covered Individualôs Date of Birth: _____

1. Is condition due to [ ] accident or [ ] sickness or [ ] disease (please check one). Please describe:

2. If Disablement is as a result of an accident please give the date that the accident occurred.

3. If Disablement is as a result of a sickness or disease, please give:

   a) Date sickness or disease first manifested itself:

   b) Date of first treatment of sickness or disease:

4. Explain fully the bodily injury or sickness or disease causing disablement, and medical treatment received (use extra sheet if necessary):

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5. Dates of Covered Individualôs total disability:

   From _____ Through _____

6. Please list all physicians seen in the past five years, including current doctor:

7. Please list all hospitals in which Covered Individual was (is) confined:

8. Are you claiming under any other insurance in respect of this disability? [ ] Yes [ ] No

   If yes please give full details

9. Please list a possible beneficiary for the survivorship benefit:

I hereby declare the above particulars are true and complete in every respect.

Covered Individualôs Signature: _____ Dated: _____

Policy Number: _____

Please attach copy of all pertinent medical records and any other documents or materials to support submission. During the claim investigation, Underwriters require your full cooperation, which may include but is not limited to an independent medical examination and your assistance in acquiring pertinent records.

Please direct all inquiries and completed form, together with executed Attending Physicianôs Statement, to:

PRO FINANCIAL SERVICES, LLC
500 West Madison Street
Suite 2660
Chicago, Illinois 60661
Toll Free: 800-832-8000
Fax: 312-376-4668