



MEMBER STATEMENT OF CONTINUANCE OF DISABILITY

Name of Member: _____ Date of Birth: ____ / ____ / ____ Plan No. 1105

Present Address: _____

City: _____ State: _____ Zip Code: _____ Telephone No. (____) _____

Check here if Change of Address

1. Progress

(a) Has there been any change in your condition during the past 12 months? Yes No

(b) If yes, please explain the nature and extent of the change in condition:

(c) Describe how your time is occupied and what your regular daily activities are: _____

2. Treatment

(a) Please provide us with complete information about the physicians you have seen during the past 12 months.

1. Doctor's full name, address and telephone number:	Date of your last visit: ____ / ____ / ____
_____	Condition being treated: _____
_____	_____
_____	_____

2. Doctor's full name, address and telephone number:	Date of your last visit: ____ / ____ / ____
_____	Condition being treated: _____
_____	_____
_____	_____

(b) Have you been hospital confined during the past 12 months? Yes No

Date(s) of Confinement ____ / ____ / ____

If yes, please list name and address of hospital: _____ Condition being treated: _____

3. Have you returned to work? Yes No Is this a new occupation? Yes No Job Title _____

(a) Date returned to work: ____ / ____ / ____

(b) From what date were you able to resume **some** duties? _____

(c) What duties were you unable to do? _____

(d) What date were you able to resume **all** of your duties? _____

(e) What are your present daily work activities? _____

(f) Do you have plans to sell/close your practice? Yes No

Date Practice sold/closed ____ / ____ / ____

- (g) If you have returned to work and wish to claim a Residual Disability Monthly Income Benefit you will need to provide document action of your "Prior Monthly Income" as well as your "Current Monthly Income".
- (1) "Monthly Income" means gross monthly income from salary, wages, fees or other remuneration earned for professional services performed by the insured Member. It does not include dividends, rent, royalties, annuities, or other forms of unearned income.
 - (2) "Prior Monthly Income" means the average "Gross Monthly Income" earned by the insured Member during the greater of either the 12 or 24 consecutive month period which ends on the first day of Total Disability which preceded the "Residual Disability" for which claim is made. Please provide monthly Revenue Statements for the 24 month period prior to your disability date.
 - (3) "Current Monthly Income" means the Member's "Monthly Income" during each month the Member claims Residual Disability Monthly Income Benefits under this policy. Please provide monthly Revenue Statements to report current monthly income.

4. Is member handling his/her own business affairs? Yes No
If no, please provide documentation showing who has legal Power of Attorney, unless this has previously been provided.

5. If you have been receiving other disability income benefits, have any terminated? If so, identify which ones and date they terminated.

I hereby certify that I have carefully read the foregoing questions and fully understand them, and that each answer is true and complete to the best of my knowledge and belief. I further understand Great-West Life & Annuity Insurance Company or its representative may request from time to time any documents which I have in my possession, supporting this statement, and I hereby agree to furnish them upon request. It is understood that the Company will make an independent investigation of this claim.

Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, having any records or knowledge of any illness, injury, medical history or treatment I have had, to furnish Great-West Life & Annuity Insurance company (the Company) all such information.

The information requested by the Company may include information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including consultations after the date this authorization is signed. Any other information the Company believes to be necessary to determine eligibility for insurance benefits may also be requested.

The information collected will be used for determining eligibility for benefits under any policies issued by the Company and for other business purposes in connection with the insurance relationship. All or part of the information collected may be sent to the Company's reinsurers, and to other insurance companies with whom I have insurance or to whom I apply for insurance. Information may be sent to persons performing business or legal functions of the Company or to persons conducting research studies or audits.

The authorization shall continue to be valid for twelve months from the date it is signed. A photocopy of this signed authorization shall be as valid as the original. I may request a copy of this authorization.

State statues in Idaho, New York, and Florida require the following language: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false or misleading information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in Florida, a felony of the third degree.)

Date

Member Signature

If this form is signed by someone other than the Member, please provide name and relationship.