GREAT-WEST FINANCIAL

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Denver, CO 80217-0410
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SUPPLEMENTAL MEMBER STATEMENT – PLAN #1106

Name: _____ Date of Birth: ___/___/___ Certificate # _____

Address: _____ Business Address: _____

_____ _____

Phone: _____ Business Phone: _____

1. Do you remain totally disabled? ☐ Yes ☐ No
   (a) If yes, complete Overhead Expenses, Treatment and Authorization Sections.
   (b) If you are currently partially disabled and wish to claim partial disability benefits proceed as indicated in item (a) above and verify the date you returned to work part time.
   (c) If you are no longer disabled, confirm the date you returned to work full time: ___/___/___.
   (d) Do you have plans to sell your practice or your share of the partnership or P.C.? ☐ Yes ☐ No
   Expected closing date of sale: ___/___/___.
   (e) Do you have a Buy/Sell Agreement or another similar type of agreement? ☐ Yes ☐ No
   (f) Do you have plans to close your practice? ☐ Yes ☐ No Closure date: ___/___/___.

OVERHEAD EXPENSES

For the time period from ____/____/____ to ____/____/____
(Documentation supporting current claimed expenses must be provided with each submission)

2. Office Premises Expenses: Rent _____
   Mortgage Interest & Real Estate Taxes _____

3. Debt Servicing: Interest on loans for:
   Purchase of Practice _____
   Furnishing Office _____

4. Employee Expenses:

Name	Date of Hire	Salary	Payroll Tax	Uniforms	Ins. Premiums	Other

5. Depreciation Expenses:*
   Office Equipment _____
   Building _____
   *(As detailed on your federal income tax return)

6. Professional Liability (Malpractice) Insurance Premiums
   Your Personal Coverage _____
   Your Employees' Coverage _____

7. Utilities Expenses:
   Water _____ Janitorial _____ Air Conditioning _____
   Electricity _____ Laundry _____ Other _____
   Telephone _____ Heat _____

8. Tax Deductible and Business Related Insurance Premiums:
   Personal and Office Liability _____ Practice Interruption _____
   Operatory and Office Contents _____ Other _____ _____
   Worker's Compensation _____ _____ _____

9. Membership Dues:
   ADA _____ Other _____ _____
   _____ _____

10. Subscriptions to Professional Journals and Magazines:

11. Accounting Fees: _____ 12. Other _____

13. (a) Please provide us with the complete information about the physician(s) you have seen in the last month.

1. Doctor's full name and address: _____ Date of your last visit _____

_____ Condition being treated _____

_____

_____

_____

2. Doctor's full name and address: _____ Date of your last visit _____

_____ Condition being treated _____

_____

_____

_____

(b) Have you been hospital confined during the past 12 months? Yes ☐ No ☐
If yes, please list name and address of the hospital?

_____

_____

Date of Admission _____/_____/_____ Date of Discharge _____/_____/_____

14. **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 statutes 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.***