NATIONAL SECURITY INSURANCE COMPANY
ELBA, ALABAMA 36323

We have received notice of your recent claim. We regret that complete information was not furnished and it will be necessary for you to furnish us with additional information so that we may process your claim.

IT IS VERY IMPORTANT THAT EACH QUESTION BE ANSWERED.

NAME ______________________________ Policy Number (s) ______________________________

Your Mailing Address ______________________________ City ______________ State ______________

Date of Birth: Month __________ Day ______ Year ______ Place of Birth: City __________ State __________

Employer ______________________________ Occupation ______________________________

Describe the nature of your illness or accident: ______________________________

____

When did you first notice you were getting sick or when did your accident occur? ______________________________

When did you first consult a doctor for this illness/accident? ______________ Name and address of attending physician: ______________

____

Name and address of any other physician treating you for this illness/accident: ______________________________

____

Have you ever suffered from this same or a similar condition before? ______________ If so, when? ______________

Name and address of physician who treated you at the time ______________________________

Is condition a result of any previous injury? __________ If so, explain ______________________________

Is condition due to injury arising out of your employment? __________ If so, explain ______________________________

____

LIST ALL OTHER HEALTH & ACCIDENT TYPE INSURANCE ON WHICH YOU HAVE FILED OR ANTICIPATE FILING CLAIM FORMS FOR THIS ACCIDENT OR ILLNESS. IF YOU HAVE NO OTHER INSURANCE INDICATE "NONE".

Name and address of Company	Amount of Daily Room and Board	Monthly Disability	Has this Company paid the current claim?
______________________________	$ __________	$ __________	Yes ( ) No ( )
______________________________	$ __________	$ __________	Yes ( ) No ( )

LIST BELOW ALL OTHER ILLNESSES OR ACCIDENTS YOU HAVE HAD REQUIRING TREATMENT WITHIN THE PAST THREE YEARS. IF YOU HAVE NOT RECEIVED TREATMENT IN THE PAST THREE YEARS, INDICATE "NONE".

Name and Address of Hospital or Doctor	Nature of Complaint	Dates continued or Dates Treated From To
______________________________	______________________	______________________
______________________________	______________________	______________________
______________________________	______________________	______________________
______________________________	______________________	______________________

I hereby certify that the above answers are true and correct.

Witness ______________________________ Signed ______________________________

Claimant

Witness ______________________________

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY"

Form No. D4-248 Rev. 06