

Instructions

Please mail or FAX this completed form to the address or number above. Please call 1-800-374-1835 with questions on how to complete this form.

1. This form should be completed in its entirety by the insured/claimant and attending physician, including the authorization to release information (Page 2).
2. To avoid an interruption in benefits, please answer all questions completely and legibly.
3. If you have any additional information you feel would help in the review of this claim, please attach to this form.

Statement of Insured

Your name _____ Date of birth _____ Soc Sec # _____

 Your address _____
(Street) (City) (State) (ZIP code)

Home telephone number _____ E-Mail Address _____

Cellular telephone number _____ Website Address _____

Have you been continuously unable to perform any work since you became disabled? yes no

If no, please list all current or past employers since becoming eligible for disability benefits under our policy (use a separate sheet if necessary):

Has your marital status changed? yes no If yes, married divorced widow/widower

Do you have any dependents other than your spouse? yes no

Indicate if you have applied for or are receiving any of the following benefits, date applied and benefit amount if approved. Other income sources include, but are not limited to, unemployment benefits, part or full-time work, internet business/sales, and other group disability income.

| | Date | Amount | Type | Date | Amount |
|---|------|--------|--------------|------|--------|
| Social Security Disability/Retirement/Widows | | | Pension | | |
| Social Security Spouse/Dependent | | | Other Income | | |

If Other Income is noted, please identify type (use as a separate sheet if necessary): _____

Describe which duties and activities you are unable to perform as a result of your disability and why: _____

List the number of hours spent each day in the following activities:

 Sitting _____ hrs/day Walking _____ hrs/day Lifting _____ hrs/day Average weight lifted _____ lbs
 Standing _____ hrs/day Traveling _____ hrs/day Bending _____ hrs/day Maximum weight lifted _____ lbs

| Names of doctors, practitioners and hospitals | Date confined/consulted | Reason for confinement/consultation |
|---|-------------------------|-------------------------------------|
| | | |
| | | |
| | | |

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for **accident and health** insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I declare that all of the above statements on this form are true and complete to the best of my knowledge.

 (Signature)

 (Date)

DISABILITY CLAIM FORM

Attending Physician's Statement (page A). Please fully complete this form. If incomplete, we will call for omitted information.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information.

| | | |
|---------------------------------|--------------------------------|------------------------------|
| Patient's name | Social security number | Date of birth |
| Physician's name (please print) | Degree | Specialty |
| Physician's street address | | |
| City | State or province | ZIP code |
| Tax ID number _____ | Physician's phone number _____ | Physician's FAX number _____ |

DIAGNOSIS

ICD-9 diagnosis code: _____ Blood pressure reading _____ / _____ Date of reading _____

Patient's height _____ Patient's weight _____

Diagnosis (including any complications) _____

Subjective symptoms

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

Is patient ambulatory? house confined? bed confined? hospital confined?

Do you believe the patient is competent to endorse checks and to direct the use of those proceeds? yes no

Is condition due to injury or sickness arising out of patient's employment? yes no unknown

HISTORY

What date did symptoms first appear or accident happen? _____

Has patient ever had same or similar condition? yes no

If yes, please provide dates and describe past treatment, including any surgical procedures: _____

NATURE OF TREATMENT (Including any type and date of surgery and medications prescribed if applicable) CPT-4 code: _____

Date of first visit _____ Date of last visit _____ Date of next visit _____

Frequency of visits weekly monthly other (specify) _____

Has patient been hospitalized? yes no If yes, name and address of hospital and date(s) of confinement: _____

CARDIAC (if applicable)

Functional capacity (American Heart Association) class 1 (no limitation) class 2 (slight limitation)

class 3 (marked limitation) class 4 (complete limitation)

METS (circle one) 1 2 3 4 5 6 7

OTHER PHYSICIAN INFORMATION

Was the patient referred to you by, or by you to, another physician? yes no If yes, please provide name and address of other physician:

Physician's name _____ Address _____

Attending Physician's Statement (page B). Please fully complete this form. If incomplete, we will call for omitted information.

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- class 1 – no limitation of functional capacity; capable of heavy work* _____ no restrictions (0-10%)
- class 2 – medium manual activity* (15-30%)
- class 3 – slight limitation of functional capacity; capable of light work* (35-55%)
- class 4 – moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- class 5 – severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks: _____

MENTAL/NERVOUS IMPAIRMENT (if applicable)

- class 1 – patient is able to function under stress and engage in interpersonal relations (no limitations)
- class 2 – patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- class 3 – patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- class 4 – patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- class 5 – patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Please define "stress" as it applies to this claimant.

What stress and problems in interpersonal relations has claimant had on the job?

Remarks: _____

PROGNOSIS

Does the patient's condition restrict employment activities? yes no

If yes, beginning on what date _____ end date _____

In an 8 hour day, patient can (restrictions/limitations):

Sitting _____ hrs/day Walking _____ hrs/day Lifting _____ lbs/max Bend/squat _____ hrs/day
Standing _____ hrs/day Traveling _____ hrs/day Pushing/pulling _____ hrs/day Crawl/climb _____ hrs/day

Explain the specific restrictions and limitations, including any other factors that may affect employment activities:

When will patient recover sufficiently to return to work:

1 month 1-3 months 4-6 months on _____ never

If never, please explain: _____

REHABILITATION

Is patient a suitable candidate for medical rehabilitation (i.e. cardiopulmonary program, speech therapy, etc.)? yes no

Is patient a suitable candidate for vocational rehabilitation? yes no

If yes, what specific restrictions and limitations would you place on vocational rehabilitation?

Date trial employment could begin? full-time part-time _____

Signature of physician _____

Date _____

Notice Requirements

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.