

STATEMENT FOR DISABILITY BENEFITS (Check appropriate box)

Disability Income Policy Disability Income Rider (DIR) Cancer Disability Waiver of Premium Rider (PW)

INSTRUCTIONS TO CLAIMANT: (Claimant's and physician's statements and HIPAA 2118C should be completed to expedite claim process).

Claimant's Name			Employer's Name		
Residence Address			Employer's Address		
City		State	City	State	Zip Code
Telephone Number ()		Zip Code	Employer's Telephone Number ()		
Date of Birth Date		Social Security Number	Current Monthly Earnings \$		
Date Last Worked		Describe your job/work/business duties and your title when disability began.			
		Is condition a result of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		Average monthly earnings for the two year period prior to disability \$			

IF ACCIDENT	IF SICKNESS
a. Describe what injury resulted	Describe nature and details of sickness
b. How did accident happen?	
c. Where did accident happen?	
d. Accident was: <input type="checkbox"/> work related <input type="checkbox"/> not work related	
e. Date of accident Date _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Date symptoms of illness first appeared Date _____
TREATMENT First treatment by a physician for this condition / /	Doctor's Name and Address
If hospitalized: Admitted / / Discharged / /	
Hospital Name	Hospital Address

Names and addresses of all physicians or practitioners and all hospitals or institutions by whom or in which you were attended, treated or examined during the last five years.

NAMES	ADDRESSES	DATES OF ATTENDANCE	DISEASE OR CONDITION

Have you ever had the same or similar injury or sickness? Yes No

If 'Yes', (a) What was the diagnosis at the time? _____

(b) When did this occur? _____

(c) Please give names and addresses of doctors and hospitals by whom or in which you were attended, treated or examined.

For purposes of this claim, I became Disabled _____ and such Disability continued/has continued to _____.

The first time I returned to work or place of business since becoming disabled was: Date _____ I returned to full time duties on: Date _____

For purposes of this claim, I became Partially Disabled _____ and such Disability continued/has continued to _____.

Of the occupational duties listed above, what duties were you not able to perform? Please describe why you were unable to perform these duties

COMPANY	TYPE	YEAR OF ISSUE	MONTHLY BENEFIT	POLICY NUMBER	BENEFIT PERIOD

<p>WORKER'S COMPENSATION</p> <p>(a) Have you received a monetary Worker's Compensation award? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) If yes, when did payment begin? ___/___/___</p> <p>(c) What amount did/are you receiving? \$ _____</p> <p>(d) The award was/is payable: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly</p> <p>(e) Give date if payments have ceased ___/___/___</p> <p>(f) Give name of worker's compensation carrier and claim number if known.</p> <p>(g) Provide the documentation to support the information given above.</p>	<p>STATE CASH SICKNESS (If you live in California, Hawaii, Puerto Rico, New Jersey, New York, Rhode Island)</p> <p>(a) Are you receiving benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) When did these benefits begin? ___/___/___</p> <p>(c) What amount are you receiving? \$ _____</p> <p>(d) Are you receiving these benefits <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly</p> <p>(e) Provide the documentation to support the information given above.</p>	<p>SOCIAL SECURITY BENEFITS</p> <p>(a) Have you applied for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Have you been approved? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Give total approved amount \$ _____</p> <p>(d) If denied, have you appealed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) Provide the documentation to support the information given above.</p>
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IMPORTANT – BE CERTAIN TO DATE AND SIGN THIS FORM AND HAVE YOUR TREATING PHYSICIAN COMPLETE THE ATTENDING PHYSICIAN'S STATEMENT PART C.

I understand that no insurance agent of the Company is authorized to make any claim decision or any representation as to whether any claim should or will be paid.

I agree to cooperate with the Company in its investigation of this claim by providing assistance including, but not limited to, completing, signing, and submitting any questionnaire or authorization form needed by the Company, in its sole opinion, to conduct its investigation.

Patient _____

Date _____ Witness _____ Signed _____

IMPORTANT NOTICE

California Residents: CAUTION: 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 Residents: 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 Residents: 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. **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.**

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 shall also be subject to a civil penalty not to exceed \$5,000 and the state value of the claim for each such violation.

Oregon Residents: Any person who, knowingly and with intent to defraud any insurance company or other person; (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: 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.

Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

ALL OTHER RESIDENTS: A law of your state requires us to inform you that 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.

PART C

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (Front and Back)

Name of Patient (Print)	Date of Birth	Policy Number
Present Address	Street	City
		State
		Zip Code

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers.

1. HISTORY

- a. When did symptoms first appear or accident happen? Date: _____
- b. Date patient ceased work because of disability? Date: _____
- c. Is condition a result of complications of pregnancy? Yes No
- d. Is condition a result of patient's employment? Yes No
- e. Is condition due to a motor vehicle accident? Yes No
- f. Has patient ever had a same or similar condition? (If yes, please describe) Yes No
- g. Names and addresses of other treating physicians _____
- h. Have you ever treated patient prior to this? (If yes, for what and when?) Yes No
- i. Does patient have other disability coverage? (If yes, please identify) Yes No

ALL PARTS OF SECTION 2, 3, 5 AND 6 MUST BE COMPLETED TO CONSIDER THIS CLAIM

<p>2. DIAGNOSIS</p> <p>a. Diagnosis (including any complications) _____</p> <p>b. Date of last examination _____</p> <p>c. Subjective symptoms _____</p> <p>d. Objective findings (include current X-rays, EKG's, laboratory data, and any clinical data) _____</p>	
<p>3. DATES OF TREATMENT</p> <p>a. Date of first visit Date: _____</p> <p>b. Date of last visit Date: _____</p> <p>c. Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify): _____</p>	<p>4. CARDIAC (If applicable)</p> <p>a. Functional Capacity (American Heart Ass'n)</p> <p><input type="checkbox"/> Class 1 (No Limitation)</p> <p><input type="checkbox"/> Class 2 (Slight Limitation)</p> <p><input type="checkbox"/> Class 3 (Marked Limitation)</p> <p><input type="checkbox"/> Class 4 (Complete Limitation)</p> <p>b. Blood Pressure (last visit) _____ / _____</p> <p align="center" style="margin-left: 100px;">Systolic Diastolic</p>
<p>5. NATURE OF TREATMENT (Surgery, medications, etc.)</p>	
<p>6. EXTENT OF DISABILITY ***IMPORTANT***</p> <p>a. Are you aware of the main duties the patient performs in his/her usual job/work/business: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Are you aware of the patient's background (education training, experience, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Is patient DISABLED from performing HIS/HER JOB/WORK/BUSINESS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If yes, give DATES of DISABILITY FROM _____ TO _____</p>	

d. If patient is able to perform some of the main duties of his/her job/work/business, please give...

DATES of PARTIAL DISABILITY FROM TO

e. Based on your knowledge of the patient's background (see 6b.), is patient **DISABLED** from performing **ALL OTHER TYPES OF JOB/WORK/BUSINESS?**

Yes No

<p>f. If still DISABLED, when will patient be able to perform HIS/HER JOB/WORK/BUSINESS DUTIES?</p> <p><input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months</p> <p><input type="checkbox"/> More than 12 months <input type="checkbox"/> Indefinite</p>	<p>g. If still DISABLED, when will patient be able to perform ANY OTHER JOB/WORK/BUSINESS? ***Base your opinion on your knowledge of patient's background (6b).</p> <p><input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months</p> <p><input type="checkbox"/> More than 12 months <input type="checkbox"/> Indefinite</p>
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h. If **PARTIALLY DISABLED**, when will patient be able to resume full duties? Date: _____

i. Date patient was able to resume his/her normal work or business activities? Date: _____

7. Do you believe the patient is competent to endorse checks and direct the use of the proceeds? Yes No

8. PROGRESS

a. Has patient... Recovered Improved Unchanged Retrogressed

If recovered, date patient able to return to work? Date: _____

b. Has patient been hospital confined? Yes No Admitted _____ Discharged _____

Please give name and address of hospital

9. 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:

10. MENTAL/NERVOUS IMPAIRMENT (if applicable)

- Class 1 - Patient able to function under stress and able to engage in interpersonal relations (No limitations)
- Class 2 - Patient able to function in most stress situations and engage in most interpersonal relations (Slight limitation)
- Class 3 - Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation)
- Class 4 - Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation)
- Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation)
- Remarks:

11. REHABILITATION

- a. Is patient a suitable candidate for rehabilitation? Yes No
- b. If yes, please explain

12. REMARKS

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE
NPI (National Provider Identifier)		*SOCIAL SECURITY OR TAX I.D. NUMBER	
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE TELEPHONE

* Public Law 89-397 requires recipients of dividend, interest or other payments to furnish Social Security Numbers or Tax Identification Numbers to payors required to report such payment to the Internal Revenue Service. This Number must be furnished to the payor whether or not the payee is required to file a tax return, or is covered by Social Security.