Disability Claim Statement—Life Insurance

ASSURANT Employee Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:
A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

If you live in the states of Arizona or New Jersey, the following statement applies to you:
A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:
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.

If you live in the state of California, the following statement applies to you:
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.

If you live in Colorado, the following statement applies to you:
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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:
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.

If you live in New Hampshire, the following statement applies to you:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Assurant Employee Benefits PO Box 973050 El Paso Texas 79997-3050
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If you live in New York the following statement applies to you:

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 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.

If you live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

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.

If you live in a state other than mentioned above, the following statement applies to you:

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.

Please read the following instructions carefully for proper completion of the attached Life Insurance Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion. If you also have Long Term Disability Insurance with Assurant Employee Benefits, completion of this form may not be necessary. Please contact the Life Benefit Center for information.

Do not separate the pages of this Claim Statement. Additional physician's statements may be obtained from the Life Benefit Center, or by copying the physician's statement included in this statement. Attach any additional physician's statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. After the Employer and Claimant Statements are fully completed, forward the entire statement to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

Instructions for completion of the Employer's sections follow:

Employer Claim Statement—Part 1

Please indicate at the top of the form whether or not this is a new claim.

1.–7. Self-explanatory.

8. Effective date of the claimant's Life coverage.

9. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.

10. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.

11. Provide the reason the claimant ceased working.

12.–13. Self-explanatory.

14. Any other coverages the claimant has with Assurant Employee Benefits. (i.e., Disability, Medical, Dental, etc.)

15. A–D If the claimant has returned to work, advise us of his/her **current** work schedule.
Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.

16.–19. The claimant's basic annual earnings as of the determination date indicated in your Life policy. For #16, if the claimant receives any bonuses, commissions, or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.

20.–23. Self-explanatory.

24. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

Employer Claim Statement—Part 2

Fully complete this section of the claim statement for **all** claims.

Please attach a copy of the employer's own description of the claimant's position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant's position. This section should be completed by someone who is familiar with the claimant's position; i.e. supervisor.

Physical Aspects

1. Self-explanatory.

2. Please tell us how often the claimant does each of the activities listed, and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.
Never = 0 hours; Occasionally = 1/2–2-1/2 hours; Frequently = 2-1/2–5-1/2 hours;
Continuously = 5-1/2 hours or more

3.–5. Self-explanatory.

Stress/Non Physical Aspects

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.

Disability Claim Statement—Life Insurance

* Required Field

ASSURANT Employee Benefits®

Employer Claim Statement—Part 1

(Please print or type.)

New claim: ☐Yes ☐No

1. Name of employer	2. Group Policy no. *	3. Group Participation no.	4. Account no.
5. Full name of claimant *	6. Social Security no.	7. Date employed	8. Effective date

9. Date last worked _____

Number of hours worked that day _____

10. Work schedule of claimant at time of disability:

_____days per week _____hours per day

11. Reason for not working after this date

12. Was plan effective when disability began? ☐Yes ☐No

If "No," please indicate date of termination _____

13. Was claimant a member of a union at the time of disability? ☐Yes ☐No

14. Does claimant have any other coverage(s) with Assurant Employee Benefits?

☐Yes ☐No If "Yes," please advise of the type of coverage(s).

15. A. Is the insured engaged in any gainful employment, even in a limited way? ☐Yes ☐No

B. If "Yes," please provide the following information:

Date insured returned to work _____

Number of hours currently working per week _____

Current salary _____

If the insured returned to work with another employer, please provide us the name and address of this employer.

_____

C. Have you and the claimant discussed reasonable accommodations which would allow a return to work? ☐Yes ☐No

If "Yes," please explain.

D. If "No," on approximately what date do you expect the insured to be able to return to work, if ever? _____

16. Basic annual salary (as defined in Policy)

17. How is claimant paid?

☐Hourly ☐Salary + Commission

☐Salaried ☐Commission only

☐Salary + Bonus ☐Other _____

18. Date of last increase in the amount of life insurance

19. Amount of life insurance as of date last worked

20. A. Has the employment of the insured been terminated solely because of disability? ☐Yes ☐No

B. If "Yes," please give date employment was terminated. _____

C. If "No," please explain present employment status. _____

21. If your group plan is on a self-administered basis, please indicate:

A. Date of last premium paid by or on behalf of insured _____

B. Mode of premium payment: ☐Monthly ☐Quarterly ☐Semi-Annually ☐Annually

22. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources?

☐Salary continuance Amount: _____per _____From _____to _____

☐Workers' Compensation Weekly benefit _____Effective date _____

☐Retirement or pension Benefit amount _____Effective date _____

☐Other _____Lump sum distribution? ☐Yes ☐No

23. Remarks

24.

Date _____By _____

AUTHORIZED SIGNATURE/TITLE

Fax no. _____Phone no. _____

Employer Claim Statement—Part 2
Physical/Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant's job.

Claimant's occupation _____

Signature/Title _____ Date _____

STAPLE YOUR OWN JOB DESCRIPTION HERE

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. of Hours	May Alternate Positions: At Will	15–30 Minutes	Hourly	Never
Sitting	_____	☐	☐	☐	☐
Standing	_____	☐	☐	☐	☐
Walking	_____	☐	☐	☐	☐
Driving	_____	☐	☐	☐	☐

2.

Claimant must	Never	Occasionally	Frequently	Continuously
A. Bend/Stoop	☐	☐	☐	☐
B. Climb	☐	☐	☐	☐
C. Reach above shoulder level	☐	☐	☐	☐
D. Kneel	☐	☐	☐	☐
E. Balance	☐	☐	☐	☐
F. Enter data/keystroke	☐	☐	☐	☐
G. Squat	☐	☐	☐	☐
H. Crawl	☐	☐	☐	☐
I. Crouch	☐	☐	☐	☐
J. Lift: Usual _____lbs.	☐	☐	☐	☐
Max _____lbs.	☐	☐	☐	☐
K. Carry Usual _____lbs.	☐	☐	☐	☐
Max _____lbs.	☐	☐	☐	☐
L. Push/Pull Usual _____lbs.	☐	☐	☐	☐
Max _____lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
   Right: ☐Yes ☐No Left: ☐Yes ☐No Both: ☐Yes ☐No
4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☐	☐	☐
B. Left	☐	☐	☐

5. Does job require:
   A. Working at unguarded heights? ☐Yes ☐No
   B. Exposure to marked changes in temperature and humidity or extremes thereof? ☐Yes ☐No
   C. Exposure to dust, fumes, gases, chemicals? ☐Yes ☐No

Stress/Non Physical

1. Percentage of time claimant spends answering customer complaints. _____%
2. Percentage of claimant's work primarily judged on production. _____%
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?
   ☐Yes ☐No _____% of time
4. How many employees does this claimant supervise? _____
5. Is this claimant routinely subject to close supervision? ☐Yes ☐No
6. Percentage of time spent by the claimant working with his/her co-workers. _____%
7. Percentage of claimant's time spent on: _____% Prescheduled activities
   _____% Random activities
8. Percentage of time claimant spends meeting deadlines set by others. _____%
9. Percentage of responsibility the claimant has for the performance of his/her particular department. _____%

DO NOT DETACH

Claimant Statement—Part 1 *(Please print or type.)*

Section I

1. Full name	2. Social Security no.	3. Date of birth
4. Address *(street, city, state, zip code)*		5. Home phone no.
6. Sex: ☐Male ☐Female	7. Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced	8. Your occupation

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred.	2. Date first unable to work because of this disability.

3. Have you returned to work? ☐Yes ☐No If "Yes," on what date: _____Part-time _____Full-time

If you have not returned to work, on what date do you expect to return to work? _____Part-time _____Full-time

4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.

Name	Address	Dates of consultation First Visit	Last Visit

5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.

Name of Hospital	Address	From	To

Section III

1. A. Has your condition prevented you from doing any job for which your education, training or experience qualifies you?
☐ Yes ☐ No

B. If "Yes," since what date has disability been total and continuous? _____

C. Are you receiving or have you applied for Social Security Disability Benefits? ☐ Yes ☐ No ☐ Ineligible

If ineligible, explain. _____

(Please forward a copy of Award or Denial letter from Social Security as soon as it is available.)

2. A. Do you expect your disability to be permanent? ☐ Yes ☐ No

B. If "No," about when do you expect to recover or be able to engage in any gainful occupation? _____

Please indicate the type of coverage provided *(Check all that apply.)*:
☐ Employer Group ☐ COBRA ☐ Conversion ☐ Individual ☐ Spouse ☐ Government ☐ Other *(Specify.)* _____

Section IV

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representatives, any and all such information. **I UNDERSTAND** the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim.
This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Signature of claimant _____Date _____

DO NOT DETACH

Claimant Statement—Part 2 (Do not complete this section if you have returned to work, or if disability is for pregnancy.)

Training, Education & Experience

1. What is your level of education?

   A. Have you received a high school diploma or the equivalent of a high school diploma? ☐Yes ☐No
   If "No," please advise us of the last grade completed. _____grade

   B. Have you attended college? ☐Yes ☐No
   ☐Some college ☐College graduate ☐Post graduate

   Please specify: Major field of study _____
   Degree earned _____
   Date last attended _____

   C. Have you attended any trade schools or received any other special training? ☐Yes ☐No

   Please specify: Type of training _____
   Date last attended _____

2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.

3. What was your occupation when disability commenced and what were the usual duties of your occupation?

4. Which of the above job duties are you unable to perform?

5. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor?
   ☐Yes ☐No

6. Have you asked your employer to provide any accommodations which would allow you to return to work?
   ☐Yes ☐No If "Yes," what accommodations did you request and what was your employer's response?

7. What accommodations do you feel could be made by your employer to allow you to return to work?

8. Have you considered retraining? ☐Yes ☐No If "Yes," what vocational area(s) would interest you?

9. Please list any hobbies, outside interests or activities.

10. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation? ☐Yes ☐No

    If "Yes," what is the name, address and phone number of the counselor handling your case?

11. Have you contacted your state Division of Vocational Rehabilitation Department? ☐Yes ☐No

    If "Yes," what is the name, address and phone number of the counselor handling your case?

DO NOT DETACH

Attending Physician's Initial Statement of Disability

ASSURANT Employee Benefits®

The patient must pay any costs for completion of this form.

To the Attending Physician
Please read the following instructions before completing this form.

Do not separate the pages of this claim statement. An authorization to release information can be found in Part 1 of the Claimant's Statement.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the reverse side of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient	Date of birth	Social Security number

History

Patient's symptoms result from *(Check all that apply.)*: ☐Employment ☐Illness

☐Auto accident *(state in which accident occurred)* _____ ☐Other accident

☐Pregnancy *(expected/actual delivery date)* _____ Type of delivery _____

Date symptoms first appeared _____ Patient's height _____ Weight _____

First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____

Frequency: ☐Weekly ☐Monthly ☐Other *(Specify.)* _____

Name(s) and address(es) of other treating or referring physician(s)

Hospital name _____ Confinement dates _____ thru _____

Diagnoses

Diagnoses *(including any complications)*
Subjective symptoms

Objective findings *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.)*

Attach medical records as appropriate.

Treatment

Describe treatment program, including dates of any surgery, medications, physical therapy or psychotherapy.

Psychiatric Impairment

Complete only 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 only limited 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 psychologic, physiological, personal and social adjustment *(severe limitations)*.
☐Remarks

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

Do you believe a legal guardian or conservator should be appointed for this patient? ☐Yes ☐No

DO NOT DETACH

Physical Impairment

☐ Class 1—No limitation; capable of heavy work*—
exert 50–100# occasionally and/or 25–50# force frequently ..... No restrictions (0–10%)
☐ Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently..... (15–30%)
☐ Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently .... (35–55%)
☐ Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—
occasional 10# of force, mostly sitting ..... (60–70%)
☐ Class 5—Severe limitation; incapable of minimal activity or sedentary* work ..... (75–100%)
☐ Bed confined ☐ House confined
☐ Remarks

*As defined in the Federal Dictionary of Occupational Titles

Cardiac

Functional capacity (American Heart Association) **Complete only if applicable.**
☐ Class 1 *(no limitation)* ☐ Class 2 *(slight limitation)* ☐ Class 3 *(marked limitation)* ☐ Class 4 *(complete limitation)*

Blood pressure *(latest reading)* _____ as of *(date)* _____
Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

Work Capabilities

DOCTOR: Check if you have reviewed the: ☐ Job Description ☐ Training, Education & Experience

Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why?

When did these limitations apply? Began _____ Ended _____

When would you anticipate a reduction of these symptoms? _____

Prognosis

Prognosis: ☐ Terminal ☐ Poor ☐ Good ☐ Excellent

Would any further therapy be reasonably expected to result in full or partial recovery?

☐ Yes *(Describe below.)* When _____ ☐ No ☐ Unknown

Has patient reached maximum medical improvement? ☐ Yes ☐ No If "No," when _____ ☐ Unknown

Rehab

Is patient a candidate for rehabilitation services? ☐ Yes *(Describe.)* ☐ No *(Explain.)*

Would job modification enable patient to work with impairment? ☐ Yes *(Describe.)* ☐ No

Would vocational counseling and/or retraining be recommended? ☐ Yes *(Elaborate.)* ☐ No

Name

Physician's name _____ Degree/Specialty _____
Address _____
STREET ADDRESS CITY STATE ZIP CODE
Telephone no. _____ Fax no. _____
Signature _____ Date _____
DO NOT PRE-DATE

DO NOT DETACH

HIPAA Authorization for Release of Protected Health Information—Life

ASSURANT Employee Benefits®

Insured/Member name _____ SS no. _____

Address _____ City _____ State _____ Zip code _____

Individual who is the Subject of Protected Health Information _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Entities possessing the information identified below, including physicians, any provider of medical services, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of the Individual referenced above.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance company of New York ("Companies").

I hereby authorize the use or disclosure of protected helth information regarding the Individual referenced above, as described below:

Description of information to be disclosed: Records concerning medical advice, care or treatment. This may also include, but is not limited to: information relating to use of drugs or use of alcohol; post-mortem examination reporting, including autopsy, toxicology and investigation reports; accident reports made by ambulance, law enforcement and paramedics; other insurance carriers or a prior life insurance carrier or life insurance policy and related claim information; and financial or employement-related information.

The sole purpose of this disclosure is for the adjudication of a claim for life insurance benefits under the Policy referenced above.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it at any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that the Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- The authorization is effective from the date signed below until a final adjudication of the claim for life insurance benefits is reached or 24 months from date of signature, whichever comes first.

_____ _____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of personal representative _____

Relationship to insured/member _____

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please make a copy of the signed Authorization for your records.

Assurant Employee Benefits is the brand name for insurance products underwritten by Union Security Insurance Company.