MEDICAL LIFE INSURANCE COMPANY

20445 EMERALD PARKWAY, SUITE 400, CLEVELAND, OHIO 44135
1-800-782-8533 (NATIONWIDE) 216-898-0685 (FAX)

GROUP NUMBER ____________________

PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED

☐ SHORT TERM DISABILITY
☐ VOLUNTARY STD
☐ WAIVER OF PREMIUM
☐ ACCIDENTAL DISMEMBERMENT
☐ SPECIFIC DISEASE BENEFIT
☐ ACCELERATED DEATH BENEFIT
☐ CRITICAL ILLNESS

CLAIMANT'S STATEMENT (Please Print)

Claimant's Name	Social Security #	Height	Weight	Birth Date

Address (Number, Street, City, State, Zip)	Phone Number A/C ( )

Name of employer	Occupation

Are you filing a claim for this disability under the Workers' Compensation Act or Social Security Act? ☐ Yes ☐ No

Describe other income you are receiving:

yes	no	type*	amount	date benefits began	date benefits terminated	Name of insurance carrier
☐	☐	Social Security (disability or retirement)	$ ___________	_________	_________	
☐	☐	State disability	$ ___________	_________	_________	
☐	☐	Retirement (normal, early or disability)	$ ___________	_________	_________	
☐	☐	Workers' Compensation	$ ___________	_________	_________	________________
☐	☐	Group disability benefits	$ ___________	_________	_________	________________
☐	☐	Other (describe) ______________________	$ ___________	_________	_________	

*****Please send a copy of your award letter, if applicable.*

1. Date of accident or beginning of sickness:____________________ Date last worked: ____________________
2. Nature of injury or illness: ____
3. If injury, describe how, when and where accident occurred: ____
4. Have you ever had same or similar illness? ☐ Yes ☐ No If yes, give dates: From ____________ To ____________
5. Name of hospital(s): ____________________ Dates confined: From ____________ To ____________

   Address of hospital(s): ____
6. Name and address of Doctor(s): ____

   Dates of treatment: ____
7. Between what dates were you unable to perform any duties? From ____________ To ____________

   From ____________ To ____________

Authorization to Release Information: I hereby authorize any hospital or physician who has attended me to disclose when requested to do so by the Medical Life Insurance Company any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

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. (not enforceable in Oregon or Virginia)

SIGNED: X .... DATED..

CLAIMANT'S SIGNATURE

Employers Statement (**italicized items should only be completed if the claim is for Waiver of Premium)

Employee's Name	Social Security #	Date of Hire	Effective date of Employee's insurance
Employer's Name			Employer's Group Number
Employer's Address City State Zip			
Last Day Worked ☐ FT ☐ PT	Date returned ☐ FT ☐ PT	Base salary $ ☐ Hourly ☐ Weekly ☐ Monthly	Class / Hours worked per week
Worker's Comp Claim filed for this Disability? ☐ Yes ☐ No	SELF ADMINISTERED ONLY: Amount of weekly disability benefit: $_________________	Claimant received: Salary continuation through ____________ Vacation through ___________ Sick Pay through ___________	
Employee's Occupation			
Premium contribution % by Employer ________ Employee ________ Employee premiums for this coverage pre-taxed? ☐ Yes ☐ No			
***Amount of Life Insurance in force:*	***Through what date were premiums paid:*		***Normal retirement age:*
Signature	Title	Date	Telephone ( )

ATTENDING PHYSICIAN'S STATEMENT (Must be completed in full at the patient's expense)

Patient's Name ______________________ Street Address ______________ City __________ State ______ Zip ________	☐ Male ☐ Female	Date of Birth	Age

1. Nature and origin of ☐ sickness ☐ injury Diagnosis (describe complications, if any): ____
2. Date symptoms first appeared or date of accident: ___________________ Date patient first consulted you for this condition: ___________________
3. Is this condition work related? ☐ Yes ☐ No ____
4. Describe any other disease or complications effecting present condition: ____
5. Date and surgical procedure(s), if any: ____
6. If maternity give estimated or actual date of delivery: ______________________________ ☐ Vaginal ☐ C-section
7. Please give dates of treatment other than surgical: ____
8. Please give hospital name & address with dates of confinement: From ________________ To ________________ ☐ Inpatient ☐ Outpatient

   Hospital Name ____________________________________ Address____
9. Has patient ever had same or similar condition? ☐ Yes ☐ No (If yes, state when and describe) ____
10. Is patient still under your care? ☐ Yes ☐ No (If discharged give date and degree of recovery) ____
11. Is the patient under the care of another physician? ☐ Yes ☐ No (If yes, provide name, address and phone # of physician)
12. Patient was or will be continuously disabled (unable to work)

    In his/her own occupation From _____________ Through _____________ In any other occupation From _____________ Through _____________

    Patient can return to work ☐ Full time ☐ Part time on _____________ ☐ Restrictions (specify) ____
13. Patient was or will be partially disabled? .... From ____________________Through____________________
14. In your opinion, is patient a candidate for rehabilitation? ☐ Yes ☐ To return to own occupation ☐ For another occupation ☐ No
15. If patient is diagnosed as terminal, is life expectancy: ☐ 6 months or less ☐ 12 months or less ☐ Other ____________________________

Remarks: ____

Physician's name ____________________________________ Office # ( ) ____________ Fax # ( ) ____________

Physician's signature ____________________________________ Date ____________________

Address ____________________________________ City ____________________ State ____________ Zip ____________

Specialty: FP ☐ IM ☐ PM&R ☐ Neuro ☐ Ortho ☐ OBG ☐ Psych ☐ Other ________________________

The laws of some states require us to furnish you with the following notice:

District of Columbia
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.

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

Kansas
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 information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

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

New Mexico
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 civil fines and criminal penalties.

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

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.

Washington
Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.