Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (877) 348-0487
Fax: (877) 404-6457

Insured's Supplemental Statement for Short Term Disability

Return to Dearborn National at:
Attention: Claims Department
P.O. Box 7071
Downers Grove, IL 60515

To Avoid Delay Please Answer ALL Questions. This form is to be completed without expense to the Company.

Claimant's Name _____ (Last) _____ (First) ___ (M.I.) SS# _____ Claim # _____

Address _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Phone Number _____ Email Address _____

Employer: _____ (Name) _____ (Street Address) _____ (City) _____ (State) _____ (Zip) Group # _____

1. Between what dates were you:
   a. Totally disabled _____ to _____ b. Partially disabled _____ to _____
2. Describe in your own words what prevents you from working _____
3. If partially disabled:
   a. What important daily duties are you unable to perform _____
   b. When do you expect to resume the majority of your duties _____
4. Do you anticipate returning to your job ☐ Yes ☐ No If so, when _____
5. Do you anticipate returning to other employment ☐ Yes ☐ No Are you seeking work? ☐ Yes ☐ No
   If yes, explain _____
6. Describe present activities _____
7. List all medication you are currently taking (name of drug, dosage, frequency) _____
8. Have you been admitted to the hospital in the past 12 months ☐ Yes ☐ No If yes, provide name and address of hospital
   Name of Hospital _____ Confined from _____ to _____
   Address _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)
9. Describe other income you are receiving

Yes/No	Type	Amount	Date Benefits Began	Date Benefits Terminated	Name of Insurance Carier
☐ Yes ☐ No	Social Security (disability or retirement)	$			
☐ Yes ☐ No	State Disability	$			
☐ Yes ☐ No	Retirement (normal)	$			
☐ Yes ☐ No	Retirement (disability)	$			
☐ Yes ☐ No	Workers' Compensation	$			
☐ Yes ☐ No	Group Disability benefits	$			
☐ Yes ☐ No	Other (describe)_____	$			

AGREEMENTS AND AUTHORIZATION: I authorize my employer to disclose all information necessary to process my claim to Dearborn National® Life Insurance Company (Dearborn National).
I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn National's claim department or its authorized representative(s) information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize Dearborn National to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.
This authorization shall expire on the date that I receive notice of Dearborn National's final decision on my claim. I understand and agree that:
· I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation;
· Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
· I should retain a duplicate copy of this authorization for my own records.;
· A photocopy of this authorization shall be as valid as the original;
I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from Dearborn National. If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, Dearborn National has the right to deny my claim.

Signature of Employee _____ Date _____

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Attending Physician's Supplemental Statement

Return to Dearborn National at:
Attention: Claims Department
P.O. Box 7071
Downers Grove, IL 60515

Name of Patient _____ SS# _____ Claim# _____

1. DIAGNOSIS
   a. Diagnosis (including any complications)_____
   b. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)_____

2. DATES OF TREATMENT
   Dates of Office Visits (Last 3 months) _____ Date of Next Scheduled Appointment_____

3. NATURE OF TREATMENT (including medications prescribed, if any) _____
   List any surgeries performed and submit copy of operative report _____

4. PROGRESS
   a. Has patient Recovered? ____ Improved? ____ Unchanged?____ Retrogressed? ____
   b. Is patient Ambulatory? ____ House confined? ____ Bed confined?____ Hospital confined? ____
   c. Has patient been hospital confined? Yes ____ No ____ If yes, give Name and Address of Hospital_____
      Confined from _____ through _____

5. CARDIAC (If applicable)
   a. Functional Capacity
      ____ Class 1 (No limitation)
      ____ Class 2 (Slight limitation)
      ____ Class 3 (Marked limitation)
      ____ Class 4 (Complete limitation)
   (American Heart Association)
   b. Blood Pressure (last visit)
      _____
      systolic/diastolic

6. 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 minimum (sedentary*) activity (75-100%)

7. MENTAL/NERVOUS IMPAIRMENT (If applicable)
   a. Please define "stress" as it applies to this claimant.
   b. What stress and problems in interpersonal relations has claimant had on job?
   ____ 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)

8. PROGNOSIS PATIENT'S JOB ANY OTHER WORK
   a. Is patient now totally disabled? Yes ____ No____ Yes ____ No____
   b.What is your prognosis of recovery? _____ Is patient permanently disabled? Yes ____ No ____
   c. Actual or Estimated Return to Work Date**(Date must be provided)** Full Time ____/____/____ Part time____/____/____
      Mo. Day Yr. Mo. Day Yr.

9. RESTRICTIONS/LIMITATIONS
   a. What duties of patient's job is he/she incapable of performing?_____
      _____
   b. Restrictions (What the patient **SHOULD NOT** do) _____
   c. Limitations (What the patient **CANNOT** do) _____
   d. Types of work duties which would be prohibited_____

Is patient currently being treated by any other practictioner or therapist? If so, list name and address:

_____

REMARKS: _____

_____

Physician's Name_____ Office #( ) _____ Fax #( ) _____
Signature_____ Date_____
Street Address_____ City or Town_____ State_____ Zip Code _____
Specialty: FP ❑ IM ❑ PM&R ❑ Neuro ❑ Ortho ❑ OBG ❑ Psych ❑ Other _____

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

FOR APPLICATIONS AND CLAIMS:

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

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.

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

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Maine & 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.

Maryland: Any person who knowingly and willingly 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 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.

Ohio: Any person who, with intent to defraud or knowingly that he 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: 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.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: 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.

Tennessee: 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.

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.

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

FOR CLAIMS ONLY:

Alaska: 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.

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.

Arkansas: 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.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

Delaware: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

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.

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

New Hampshire: 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.

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

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.

FOR APPLICATIONS ONLY:

Massachusetts: 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.