SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

RETURN COMPLETED FORM TO:

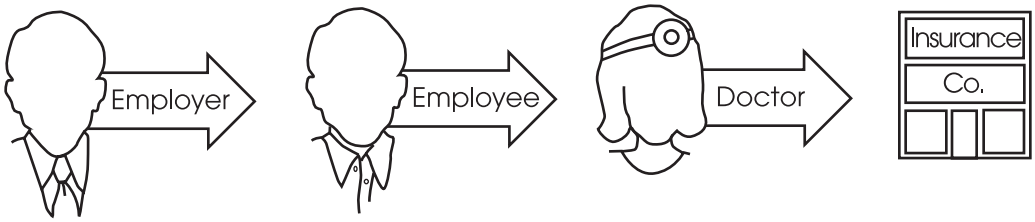
CLAIMS DEPARTMENT
SECURITY MUTUAL LIFE INSURANCE
COMPANY OF NEW YORK
P.O. BOX 1625
BINGHAMTON, NY 1392-1625

Group

Long Term Disability

CLAIM

POLICYHOLDER CERTIFICATION



EMPLOYER — *form completion information*

NOTICE OF CLAIM — Instructions

At approximately 30 days before end of elimination period:

A. **Complete** the **Employer's Report of Claim Form**. Transmit the completed form to:
Security Mutual Life Insurance Company of New York
P.O. Box 1625
Binghamton, NY 13902

INCLUDE
- Job description (detailed duties)
- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment
- Documentation of earnings if other than straight salary
- If Workers' Compensation claim filed, include copy of First Report of Accident and the decision

B. Provide claimant with the accompanying Claim Application Forms:
Application for Group LTD – Instructions
Authorization for Disclosure of Health and Other Information
Employee's Disability Benefits Application
Attending Physician's Statement**

REQUEST
- Birth certificate (short duration claim and under age 50 not necessary at this time)
- Copy of awards from other source of benefits: Social Security, Workers' Comp., retirement, state disability, others

C. **All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.**

****If claimant has more than one treating physician, provide claimant with additional Attending Physician's Statement forms**

EMPLOYER'S REPORT OF CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT

1. Employee's Name
2. Social Security No.
3. Date of Birth
4. Address | City | State | Zip Code

EMPLOYMENT

5. Insurance Class
6. Employee Date of Hire
7. Date employee became Insured for LTD
8. Date employee was actually last present at work
9. Occupation at time last worked (attach job description)
10. Work schedule at time last worked

    No. of days per week_____ No. of hours per day_____
11. Reason for stopping:
    ☐ Sickness ☐ Granted LOA ☐ Laid Off
    ☐ Retired ☐ Dismissed ☐ Other
    ☐ Resigned ☐ Vacation
12. Has employee returned to work?
    ☐ Yes ☐ Part-time ☐ Full-time
    ☐ No Date_____ Date_____

INCOME

13. How is employee paid?
    ☐ Straight Salary ☐ Hourly
    ☐ Salary & Commissions
    ☐ Commissions Only ☐ Salary & Bonus
14. Employee's Basic Monthly Earnings

    $_____ LTD Benefit_____

    (If salary is based on less than 12 mos. – No. of mos._____)
15. Employee's % of LTD premium contribution:

    Employee pays_____ Employer pays_____
16. Is Employee Contribution:

    Pre-Tax ____ or, After Tax ____

OTHER BENEFITS

17. Has insured received other disability payments since time last worked?

    Salary Continuance: ☐ Yes Wkly Amt._____ Date benefits cease _____ ☐ No

    Insured Short Term: ☐ Yes Wkly Amt. _____ Date benefits cease _____ ☐ No

    Other Type: ☐ Yes Wkly Amt._____ Date benefits cease _____ ☐ No
18. Did claim result from job activity?
    ☐ Yes (Explain)
    ☐ No
19. Has Workers' compensation claim been filed?
    ☐ Yes ☐ Pending ☐ Denied (Enc. copy)
20. Workers' compensation Wkly Amt.

    $_____

    (Inc. copy of 1st report of accident)

RETIREMENT

21. Is employee covered by employer sponsored retirement plan?
    ☐ Yes ☐ No
22. Does retirement plan contain a disability provision?
    ☐ Yes ☐ No
23. Is employee or will this employee be eligible for a disability or retirement pension?
    ☐ Yes If "Yes" type:
    ☐ No

    Monthly Amount $_____
    ☐ Disability
    ☐ Retirement
    ☐ Other_____
    Commence Date of Benefits:_____
    (enclose copy of summary plan description)

NOTE: **If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.**

CERTIFICATION

24. Employer's Name (state association and name of policyholder, if other)
25. Telephone No.
26. Group Policy No.
27. Address
28. Employer (Taxpayer) I.D. Number (EIN) _____ – _____

    OR

    29. Public Employer Social Security No. 69 _____ – _____
30. Name of person completing this form (please type or print)
31. Signature of Authorized Insurance Representative | Title | Date

Send this form (with other enclosures) to address on Page 1. Give remaining portions of form to claimant for completion.

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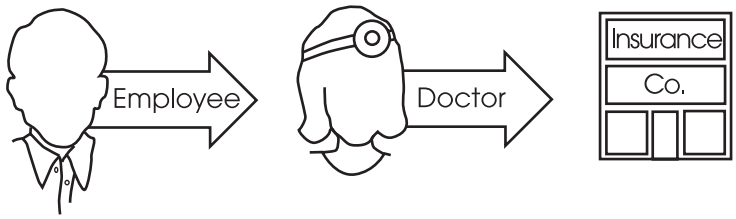
Group

Long Term Disability

CLAIM

APPLICATION



EMPLOYEE — *form completion information*

Application for Group LTD – Instructions

A. **Complete** and **Sign** the **Authorization for Disclosure of Health and Other Information**. This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments.

B. **Complete Employee's Disability Benefits Application in FULL.**
ATTACH
- a copy of your birth certificate
- a copy of Social Security and other income entitlement awards (or forward when received)

C. **Give** the physician who is treating you this entire packet of forms, including these instructions, the **Attending Physician's Statement,** the **Authorization for Disclosure of Health and Other Information** and the **Employee's Disability Benefits Application** (if you have more than one physician, obtain additional **Attending Physician's Statements** from your employer). Instruct your attending physician to send all three forms to:

Security Mutual Life Insurance Company of New York
P.O. Box 1625
Binghamton, NY 13902

D. When the completed **Attending Physician's Statement**, **Authorization for Disclosure of Health and Other Information** and **Employee's Disability Benefits Application** are received by Security Mutual Life Insurance Company of New York, they will advise you on your eligibility for benefits or of any additional information that may be needed.

The Laws of some states require us to furnish you with a fraud warning notice:

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

Please see the next page for state-specific fraud warning notices.

FRAUD WARNING NOTICES

Unless specific state language is provided below, the following general fraud notice applies: *Any person who knowingly and with intent to defraud any insurance company 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 and subjects such person to criminal and civil penalties.*

If you are a resident of any of the following states, please read the notice for the state in which you reside.

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, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for 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 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.

Delaware, Idaho, Indiana and 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to any 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: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

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.

Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland: 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.

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 false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 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.

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.

New York: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with the intent to defraud or knowing 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

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 are 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.

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.

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Group LTD CLAIM

Authorization for Disclosure of Health and Other Information (HIPAA)

Authorization – to be completed by employee

I hereby authorize the disclosure of information about me as set forth below.

Who I am authorizing to disclose information: Any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medical or medically related facility, insurance company, government agency, Social Security Administration, the Medical Information Bureau, my employer or any other organization, institution or person who has attended me or has any records or knowledge of me or my health.

To whom information may be disclosed: Security Mutual Life Insurance Company of New York, or its representatives such as its attorneys, investigators, reinsurers or service providers (collectively, "Security Mutual").

Information to be disclosed: Any and all information with respect to any illness, including mental illness, drug or alcohol abuse or HIV/AIDS, injury, medical history, consultations, prescriptions, treatments, or benefits, and copies of all hospital and medical records, motor vehicle records, and employment and payroll records.

Purpose of disclosure: Information will be used by Security Mutual to determine eligibility for insurance benefits.

Expiration Date of this Authorization/Revocation: This Authorization shall remain valid for the duration of the claim for benefits, unless I revoke it in writing.

Additional Statements

1. I agree that a copy of this Authorization shall be considered as effective and valid as the original.
2. I understand that my failure to sign this Authorization, or subsequent revocation of this Authorization may result in denial of benefits by Security Mutual.
3. I understand that there is a potential for information used or disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by federal HIPAA privacy rules.
4. I understand that I may revoke this Authorization at any time, by mailing written notice to Security Mutual at the address shown above. I understand that a revocation is not effective to the extent that any person has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.
5. I understand that I may request to receive a copy of this Authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

TO BE COMPLETED BY EMPLOYEE

CLAIMANT

1. Full Name (Last, First, Middle Init.)
2. Social Security No.
3. Phone Number
4. Address / City / State / Zip Code
5. Date of birth (Mo. Day Year)
6. Height
7. Weight
8. Sex ☐ M ☐ F
9. Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
10. Spouse's date of birth (Mo. Day Year) First Name
11. Is spouse employed? ☐ Yes ☐ No
12. Number of children (Under age 19)
13. List names and dates of birth of unmarried children who have not finished high school.

EMPLOYMENT

14. Employer's Name
15. Group Policy No.
16. Occupation (List the duties of your occupation at the time of disability)
17. Date of accident or date first noticed symptoms of illness: Mo. Day Year
18. I have been unable to work because of the disability since: Mo. Day Year
19. I returned to work on a part time basis on: Mo. Day Year
20. I returned to work on a full time basis on: Mo. Day Year
21. Is your accident or illness related to your occupation? ☐ Yes ☐ No
22. If "yes," explain

    Have you or do you intend to file a Workers' Comp. Claim? ☐ Yes ☐ No

CLAIM HISTORY

23. Describe how and where accident occurred or describe the onset and nature of your illness.
24. Date you were first treated for your illness or injury (Mo. Day Year)
25. Treated by:

    Hospital:_____ (Name / Street Address / City / State / Zip Code)

    Doctor:_____ (Name / Street Address / City / State / Zip Code)
26. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No (If yes complete No. 27.)
27. Treated by:

    Hospital:_____ (Name / Street Address / City / State / Zip Code)

    Doctor:_____ (Name / Street Address / City / State / Zip Code)

INCOME

28. Describe other income you are receiving:

Yes	No	type	amount	date began	date term.
☐	☐	Social Security (disability or retirement)	$_____	_____	_____
☐	☐	State disability	$_____	_____	_____
☐	☐	Retirement (normal, early or disability)	$_____	_____	_____
☐	☐	Workers' Compensation	$_____	_____	_____
☐	☐	Group disability benefits	$_____	_____	_____
☐	☐	Other (describe) _____	$_____	_____	_____

BENEFIT

29. Have you, or do you plan to apply for benefit described above?

    Type_____ Date application filed_____

    Type_____ Date application filed_____
30. If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purposes? ☐ Yes ☐ No If "yes" Amt. $_____ (Indicate amount per week $20.00 min.) _____ (Signature)

The above statements are true and complete to the best of my knowledge and belief. I have read the applicable fraud warning notice on the instruction page.

_____ Signature of Employee _____ Date

ATTENDING PHYSICIAN'S STATEMENT

Mail completed form to:
Security Mutual Life Insurance Co. of New York
P.O. Box 1625
Binghamton, NY 13902-1625

Name of patient	Date of birth

HISTORY

(a) When did symptoms first appear or accident happen?

(b) Date patient ceased work because of disability?

(c) Has patient ever had same or similar condition?
☐ Yes ☐ No If "Yes" state when and describe

(d) Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☐ No ☐ Unknown

(e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (Including complications)

(b) If pregnancy, est. date of delivery

(c) Subjective symptoms

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

TREATMENT

(a) Date of first visit

(b) Date of last visit

(c) Frequency
☐ Weekly ☐ Monthly ☐ Other (Specify)

(d) Nature of treatment (Including surgery and medications prescribed, if any)

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_____

CARDIAC

(a) Functional capacity (American Heart Ass'n.)
☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood Pressure (last visit)
_____
systolic/diastolic

IMPAIRMENTS

(a) Physical Impairments (*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%)
Remarks:

(b) Mental Impairments (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)
Remarks:

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ☐ Yes ☐ No; ANY OTHER WORK ☐ Yes ☐ No

(b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future? ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mo. ☐ Never Applies To: ☐ Patient's Job ☐ Other Work

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☐ Yes ☐ No; ANY OTHER WORK ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

REHAB

(c) When could trial employment commence?
Date:_____ PATIENT'S JOB ☐ Full-time ☐ Part-time
Date:_____ OTHER WORK ☐ Full-time ☐ Part-time

REMARKS

(Limitations, Therapy, etc.)

Name (Attending Physician) Print	Degree	Telephone

Street Address	City or Town	State or Province	Zip Code

Signature	Date