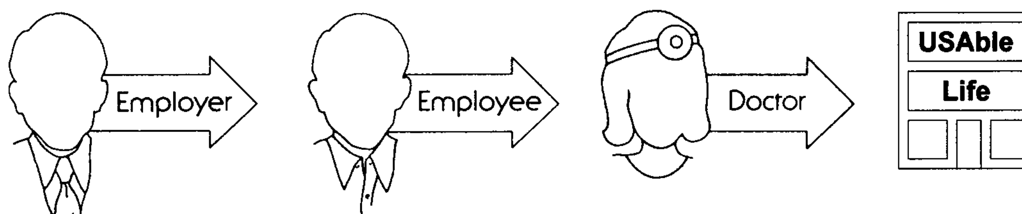
Attention: Claims Department
One Riverfront Plaza Westbrook, ME 04092-9700
Telephone (877) 254-0085
Fax (207) 591-3048

Group Long Term Disability CLAIM

POLICYHOLDER CERTIFICATION



EMPLOYER — *form completion information*

NOTICE OF CLAIM — Instructions

At approximately 30 days before end of elimination period:

1. Complete the back of this form in full and transmit this portion only to address above.

   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.

2. Give remaining pages to claimant for completion.

   Request
   - Birth certificate (short duration claim and under age 50 not necessary at this time).
   - Copy of awards from other sources of benefits: Social Security, Workers' Compensation, retirement, state disability, any other income.

3. If claimant has more than one treating physician, give claimant additional forms for completion.

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

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 work:

    ❑ 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 ______ Hrly Rate
    ❑ 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 ______%

OTHER BENEFITS

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

    Salary Continuance: ❑ Yes Wkly. Amt. ______ Date benefits cease ______ ❑ No

    Insured Short Term Disability: ❑ Yes Wkly. Amt. ______ Date benefits cease ______ ❑ No

    Other Type: ______ ❑ Yes Wkly. Amt. ______ Date benefits cease ______ ❑ No

17. Did claim result from job activity?

    ❑ Yes (Explain)
    ❑ No

18. Has Workers' Compensation claim been filed?

    ❑ Yes ❑ No
    ❑ Pending ❑ Approved (Attach Copy)
    ❑ Denied (Attach copy)

19. Workers' Compensation Weekly Amount $______

    Name & Address of Workers' Comp. Carrier ______

RETIREMENT

20. Is employee covered by employer sponsored retirement plan?

    ❑ Yes ❑ No

21. Does retirement plan contain a disability provision?

    ❑ Yes ❑ No

22. Is employee or will this employee be eligible for a disability or retirement pension?

    ❑ Yes If "Yes" type:
    ❑ No

    Monthly Amount $______

    ❑ Disability
    ❑ Retirement
    ❑ Other ______

    Date Benefits Began or Will Begin: ______
    (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

23. Employer's Name (state association and name of policyholder, if other)
24. Telephone No. (   )
25. Fax No. (   )
26. Group Policy No.
27. Address — City — State — Zip Code
28. Employer (Taxpayer) I.D. Number (EIN) ______ - ______

    OR

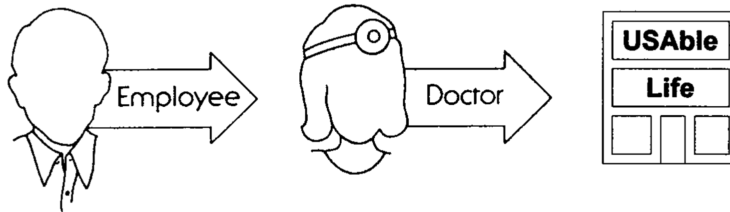
29. Public Employer Social Security No. 69 ______ - ______
30. Name of person completing this form (please type or print)
31. Signature of Authorized Insurance Representative
32. Title
33. Date

CL - LTD DRMS (9-05)

Separate and send this form (with other enclosures) to address on reverse side.
Give remaining portions of form to claimant for completion.

Attention: Claims Department
One Riverfront Plaza Westbrook, ME 04092-9700
Telephone (877) 254-0085
Fax (207) 591-3048

Group
Long Term Disability
CLAIM
APPLICATION



EMPLOYEE — *form completion information*

APPLICATION FOR GROUP LTD - INSTRUCTIONS

1. **Complete the employee statement and sign the Authorization for Release of Information.** This will allow USAble Life or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).

2. **Obtain and sign an Authorization for Release of Medical Records.**

3. **Complete employee claim statement in full.**

   Attach:
   - a copy of your birth certificate if disability duration is indefinite or permanent.
   - a copy of Social Security and other income entitlement awards (or forward when received).

4. **Give the Authorization and the claim application to the physician treating you** (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours and the authorizations to: USAble Life, Attention: Claims Department, One Riverfront Plaza, Westbrook, ME 04092-9700.

5. When the forms are received by USAble Life, we will advise you of your eligibility for benefits or of any additional information that may be needed.

DO NOT DETACH

GROUP LTD CLAIM

EMPLOYEE'S Authorization for Release of Information

AUTHORIZATION – to be completed by employee

Policy No. ____________________

The above statements are true and complete to the best of my knowledge and belief, and I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state, or local), the Social Security Administration, or other organization or person, that has any information, records or knowledge of me, my benefits or my health, past or present, to furnish such information to USAble Life (or its representatives) and to permit them to examine and copy such information. I understand that USAble Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the Company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge I have a right to a copy of this authorization upon request.

FRAUD WARNING: Except as noted in the Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

____________________	____________________
Date	Employee's Signature
____________________	____________________
Relationship of Authorized Person, if other	Authorized Person's Signature

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: 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.

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.

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

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

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.

EMPLOYEE'S STATEMENT OF CLAIM

TO BE COMPLETED BY EMPLOYEE

CLAIMANT

1. Employee's Name (Last, First, Middle Initial)
2. Social Security No.
3. Date of Birth
4. Address — City — State — Zip Code — Telephone No. ( )
5. Height
6. Weight
7. Sex ❑ M ❑ F
8. Marital status ❑ Single ❑ Married ❑ Widowed ❑ Divorced
9. Spouse's date of birth MO. DAY YEAR — First Name
10. Is spouse employed? ❑ Yes ❑ No
11. Number of children (Under age 19)
12. List names and dates of birth of unmarried children who have not finished high school

EMPLOYMENT

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

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

CLAIM HISTORY

22. Describe how and where accident occurred or describe the onset and nature of your illness:
23. Date you were first treated for your illness or injury MO. DAY YEAR
24. Treated by:

Hospital: ______ Name — Street Address — City — State — Zip Code

Doctor: ______ Name — Street Address — City — State — Zip Code

25. Have you ever had the same or similar condition in the past? ❑ Yes ______ Date ❑ No If yes complete No. 26
26. Treated by:

Hospital: ______ Name — Street Address — City — State — Zip Code

Doctor: ______ Name — Street Address — City — State — Zip Code

INCOME

27. Describe other income you are receiving

yes	no	type	Amount	Date Began	Date Term'd
❑	❑	Social Security (disability or retirement)	$		
❑	❑	State disability	$		
❑	❑	Retirement (normal, early or disability)	$		
❑	❑	Worker's Compensation	$		
❑	❑	Group disability benefits	$		
❑	❑	Other (describe) ______	$		

BENEFIT

28. Have you, or do you plan to apply for any benefit described above which you are not currently receiving?

Type ______ Date application filed ______

Type ______ Date application filed ______

29. 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" Amount $______ Indicate amount per month ($87.00 minimum)

______ Signature

The above statements are true and complete to the best of my knowledge and belief.

______ Signature of employee

______ Date

ATTENDING PHYSICIAN'S STATEMENT

IMPORTANT INFORMATION: Information on the Attending Physician's Statement should only be completed by the physician or an authorized member of his/her staff.

RETURN TO:
Claims Department
USAble Life
One Riverfront Plaza
Westbrook, ME 04092-9700
Telephone (877) 254-0085
Fax (207) 591-3048

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 If "Yes" state when and describe ❑ No

(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) and ICD-9 Code:

(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 of visits ❑ 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 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%)

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 Mos. ❑ Never
Applies To: ❑ Patient's Job ❑ Other Work

REHAB

(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

(c) When could trial employment commence?
Date__________ PATIENT'S JOB ❑ Full-time ❑ Part-time
Date__________ ANY OTHER WORK ❑ Full-time ❑ Part-time

REMARKS

(Limitations, Therapy, etc.)

Name (ATTENDING PHYSICIAN) Print	Degree	Fax No. ( )	Telephone No. ( )

Street Address	City or Town	State or Province	Zip Code

Signature	Provider Tax ID #	Date