MetLife

Information needed from you and your physician

Use this form to provide us with the information we need from you and your physician to process your claim for disability benefits.

Metropolitan Life Insurance Company

Instructions:

- You should complete and sign Section 1 of this form before giving it to your physician. If the form is sent directly to your physician, you may have your physician complete Section 1 for you. Submitting an incomplete form may delay processing your claim.
- Please make sure to write your name and claim number at the top of pages 2 to 4. If the pages get separated, this will help to ensure timely processing.
- Some physicians may charge for completion of this form. Any such charge would be your responsibility.
- If you live or work in 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Section 1 can be completed by either you or your physician. Section 2 **MUST** be completed by your physician.

To be completed by the person submitting the claim, or by the physician if received directly.

SECTION 1 - About you

Employee - First name	Middle name	Last name

Employee birth date *(mm/dd/yyyy)*	Employer name	Occupation

Physician - First name	Middle name	Last name

Physician phone number	Claim number

Authorize your physician to share your medical information with us

I authorize my physician to release any information collected in the course of examining or treating me as a patient.

Employee signature	Date signed *(mm/dd/yyyy)*

REQUIRED information in case pages get separated:

First name	Middle name	Last name	Claim number

To be completed by the physician providing treatment for the disability condition.

SECTION 2 - Information about your patient's health

- Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.
- **After you complete this form, you can fax it along with office notes and results from any diagnostic testing related to your patient's condition (e.g., x-ray, lab tests, EKG or MRI) to 800-230-9531.**

History of your patient's condition

First date of treatment for this condition *(mm/dd/yyyy)*	Most recent date of treatment *(mm/dd/yyyy)*

What is the cause of your patient's symptoms? *(Check one.)*

☐ Injury ☐ Illness ☐ Pregnancy - Type of birth: *(Check one.)*
☐ Caesarean ☐ Natural birth ☐ Not yet delivered: Expected delivery date *(mm/dd/yyyy)* _____

List any other physicians or specialists you referred your patient to:

First name	Middle name	Last name	Specialty	Phone

Is your patient's condition work-related? ☐ Yes ☐ No

Did you advise your patient to stop working? ☐ Yes On date *(mm/dd/yyyy)* _____ ☐ No

Has your patient been hospitalized for this condition? ☐ Yes On date *(mm/dd/yyyy)* _____ ☐ No

Facility name	Street address

City	State	ZIP code

About the diagnosis and treatment of your patient

Primary diagnosis code	Description

Secondary diagnosis code	Description

List the symptoms your patient reported to you.

List your clinical findings and reports. *(Please include copies of results when you fax this form to us.)*

REQUIRED information in case pages get separated:

First name	Middle name	Last name	Claim number

Describe the treatment plan you recommend for your patient.

If surgery has been performed or is anticipated, provide:

CPT–4 procedure code	Description	Date *(mm/dd/yyyy)*

List any medications prescribed.

Medication name	Dosage

About your patient's restrictions and limitations

Your patient's dominant hand: *(Check one.)* ☐ Right ☐ Left

How many hours in a workday can your patient:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Sit		☐	☐		
Stand		☐	☐		
Walk		☐	☐		
Climb		☐	☐		
Twist/Bend/Stoop		☐	☐		
Reach above shoulder level		☐	☐		
Reach front and side at desk level		☐	☐		
Perform fine finger movements		☐	☐		
Perform eye/hand movements		☐	☐		

How many hours in a workday can your patient lift or carry:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

How many hours in a workday can your patient push or pull:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

Can your patient operate a motor vehicle? ☐ Yes ☐ No

Is your patient at maximum medical improvement? ☐ Yes ☐ No

REQUIRED information in case pages get separated:

First name	Middle name	Last name	Claim number

Please make any additional notes.

About your patient's prognosis

Have you advised your patient about when they can return to work?

☐ Yes *(Check all that apply.)*

- ☐ To regular occupation. On date *(mm/dd/yyyy)*_____ ☐ Full-time ☐ Part-time ☐ Modified duty
- ☐ To any other occupation. On date *(mm/dd/yyyy)*_____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ No *(Please explain.)*

List any restrictions to work or activity. *(Please be as specific as possible.)*

If we need more information, who's the best person at your office to contact?

SECTION 3 - Physician's signature and information

Signature		Date signed *(mm/dd/yyyy)*	
First name	Middle name	Last name	
Street address		Degree or specialty	
City		State	ZIP code
Office phone number	Fax number	Tax ID	

SECTION 4 - How to submit this form

Please send the first four pages of this form and any supporting documents to MetLife Group Disability by:

Mail:
Metropolitan Life Insurance Company
PO Box 14590
Lexington, KY 40512-4590

Fax:
1-800-230-9531

Please write your patient's claim number on any documents you send.

We're here to help

Please don't hesitate to contact us if you have any questions.

Physician: You can reach us at 1-866-463-6377, Monday through Friday, 8:00 a.m. to 11:00 p.m. Eastern time.

SECTION 5 - Insurance fraud warnings

Before signing this form, please read the warning for the state where you reside or work and, if you are submitting a claim for disability income benefits, the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia:

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.

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 loss is subject to criminal and civil penalties.

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 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 the 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.

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

Kentucky: Any person who knowingly and with the 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Hampshire: A 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.

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term 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.

Pennsylvania and all other states: 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 a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

LONG TERM DISABILITY CLAIM FORM EMPLOYEE STATEMENT

MetLife

Metropolitan Life Insurance Company

P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

Instructions for completing the claim form:

1. Complete all applicable areas of the claim form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the claim form.
4. Fax this form to expedite your claim – retain original for your records.
5. *Contact MetLife at 888-444-1433 for any questions you have on completing this form.

Section 1: Personal Information

Name (Last, First, MI) – MUST ANSWER	**Employer –** MUST ANSWER	**Group Report #**	**ID Number**

Address City State Zip Code	Date of Birth (MM/DD/YY)	Sex ☐ M ☐ F	**Social Security #** MUST ANSWER

We require a street address for our records if a P.O. Box is your mailing address

Home Phone #	Work Phone #	Occupation	Marital Status ☐ Married ☐ Single ☐ Other	Tax Exemptions

Dependent Information:

	Name	Date of Birth	SS#
Spouse			
Children			

Section 2: Claim Information

Is your disability due to ☐ Injury/Accident? ☐ Illness?	If due to injury/accident, give date, time and details.
Is this condition work related? ☐ Yes ☐ No	(When, Where, How)

Date of first treatment for this condition	**Date Last Worked** MUST ANSWER	Date Disability Began	Height	Weight

Name, address, phone number of your primary attending physician.

Name of physicians/providers who have treated you within the past 2 years.

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason for Visit
		From To	
		From To	
		From To	

Has the patient been hospitalized? ☐ Yes ☐ No If Yes, give dates from _____ to _____ ☐ Inpatient ☐ Outpatient
Name and address of hospital

Circle Highest Education Level Completed.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Degrees, Certificates, License/Skills or training obtained

Please describe what prevents you from performing the duties of your job.

Have you applied for or are you receiving income from any other sources? ☐ Yes ☐ No
If yes, provide the following information.

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	☐	☐			
Short Term Disability	☐	☐			
Worker's Compensation	☐	☐			
State Disability	☐	☐			
Social Security	☐	☐			
Dependent Social Security	☐	☐			
No Fault (Income Replacement)	☐	☐			
Retirement/Pension	☐	☐			
Permanent Total Disability	☐	☐			
Other (Please Identify)	☐	☐			

EES LTD 5323 (09/18) Fs

Name: (Last, First, Middle Initial)	Social Security #	Report #	Claim #

Agreement To Reimburse Overpayment of Long Term Disability Benefits

I,_____ acknowledge that, if my disability claim is or has been approved, under my Long Term Disability coverage, Metropolitan Life Insurance Company (MetLife) is authorized to reduce the benefits otherwise payable to me by certain amounts paid or payable to me under disability or retirement provisions of the Social Security Act (including any payments for my eligible dependents), under a Worker's Compensation or any Occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

I understand that, if my disability claim is or has been approved, MetLife is willing to make advance monthly disability payments to me, which because of amounts paid or payable under the laws described above may be in excess of the benefits actually due to me. However, I also understand and accept that MetLife will make these payments, only if I make certain statements which I represent and warrant to be true and only if I agree as follows:

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefit payment or a compromise settlement.

2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my Plan of Benefits after I have received my first monthly benefit check from MetLife. As proof of this, I agree to send to MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application.

3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my claim for benefits as specified in my Plan of Benefits.

4. As specified in my Plan of Benefits, when I, my spouse or my dependents receive any disability or retirement payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award, notification or check to MetLife.

5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, as specified in my Plan of Benefits, I agree to repay to MetLife any and all such amounts which MetLife or employer has advanced to me in reliance upon this Agreement.

6. If for any reason MetLife or employer is not repaid, then I understand that MetLife may reduce my monthly benefit below the minimum monthly benefit amount as stated in my Plan of Benefits, until the overpayment is reimbursed in full.

7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

I understand that when MetLife issues an advance, it is relying on my statements and agreements herein. My acceptance of an advance, along with my signature below, is my acceptance of terms of this Agreement.

Witness Signature	**Date**	**Claimant's Signature**	**Date**

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Instructions for completing the form:

1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

Name of Employee (Please Print)	**Date of Birth** mm/dd/yy
Claim Number:	**ID Number:**

Authorization to Disclose Information About Me

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any workers compensation, employee assistance or disease management program, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and disability claim.

2. **I permit:** MetLife to disclose to my employer or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, workers compensation, employee assistance, or disease management programs, any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

I understand that I may revoke this authorization at anytime by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40512-4590, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

Signature of Employee	**Date**

EES LTD 5323 (09/18) Fs

Disability Claim Employee Statement (Continued)

Fraud Warning:

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia – 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.

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 loss is subject to criminal and civil penalties.

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 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 the 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.

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

Kentucky – Any person who knowingly and with the 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Hampshire – A 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.

Oregon and Vermont – Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Disability Claim Employee Statement (Continued)

Fraud Warning *(continued)*:

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term 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.

Pennsylvania and all other states – 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 a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Name of Employee (Please Print):_____ Social Security Number:_____

Signature of Employee:_____ Date:_____

LONG TERM DISABILITY CLAIM FORM EMPLOYER STATEMENT

MetLife

Metropolitan Life Insurance Company

P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
2. Sign the claim form.
3. Fax this claim form to expedite your claim – retain original for your records.

Section 1: Employer Information

Name of Employer - MUST ANSWER	Group Report #	Sub-Division #	Branch #

Address City State ZIP Code	Employer Tax ID#

Subsidiary or Division Name	Address

Contact Person's Name	Phone #

Section 2: Employee Information

Name (Last, First, MI) - MUST ANSWER	**Social Security # - MUST ANSWER**	Date of Birth (MM/DD/YY)	Sex ☐ M ☐ F

Address City State ZIP Code	Home Phone #

Marital Status ☐ Married ☐ Single ☐ Other	W4 Filing Status Exemptions:	Date of Hire	Current Occupation	How long at this occupation?

Work Location Address	Employee ID #	Work Phone #

Supervisor Name	Phone #

Section 3: Claim Information

Is claim due to ☐ Injury? ☐ Illness?	Description of illness or injury (including date of accident):
Is condition work-related? ☐ Yes ☐ No	

If yes, provide name and address of Workers' Compensation Carrier.

Name _____ Address _____

Contact Person's Name _____ Phone # _____ Worker's Comp. Claim # _____

Date Last Worked MUST ANSWER	First Date of Absence	Date Returned to Work ☐ Actual ☐ Estimated	Eff. Date of Coverage	Earn. On Last Day Worked	Benefit Rate

Premium Contributions ☐ Pre-tax Employer _____ % Employee _____ % ☐ Post-tax	Basic Earnings (exclusive of overtime, bonus, etc.) $ _____ ☐ Hourly ☐ Weekly ☐ Monthly	Average Hours Worked Per Week

Employee's Status As Of First Day Absent If other than active, Please explain	☐ Active ☐ Vacation ☐ LOA ☐ Laid Off ☐ Terminated ☐ Retired	LTD: Date Enrollment Card Signed	If buy up: Date Enrollment Card Signed

Has employee had previous absences from work due to disability? ☐ Yes ☐ No If yes, provide dates and medical conditions

Can employee's job be modified? ☐ Yes ☐ No If yes, describe how.	Has return to work been discussed with employee? ☐ Yes ☐ No

To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the following sources:

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	☐	☐			
Short Term Disability	☐	☐			
Workers' Compensation	☐	☐			
State Disability	☐	☐			
Social Security	☐	☐			
Dependent Social Security	☐	☐			
No Fault (Income Replacement)	☐	☐			
Retirement/Pension	☐	☐			
Permanent Total Disability	☐	☐			
Other (Please identify)	☐	☐			

Continued on following page

Section 4: Employee's Job Description

Name of Employee: _____ **Usual Days Worked** _____ **/per week**

Employee's Job Title: _____ **Hours Worked** _____ **/per week**

Social Security Number: _____ **Claim Number** _____

This section should be completed by someone who is familiar with the employee's job functions (e.g. manager or supervisor). Complete all sections. This section must be completed AND you must also attach a copy of your company's job description for the employee.

Name of Person Completing This Section:

_____ Title: _____

Signature: _____ Date: _____

Place an X in each of the appropriate boxes to describe the extent of the specific activity performed by this employee.

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
1. Sitting					
2. Standing					
3. Walking					
4. Bending Over					
5. Twisting					
6. Climbing					
7. Reaching Above Shoulder Level					
8. Crouching/Stooping					
9. Kneeling					
10. Balancing					
11. Pushing and Pulling					
12. Repetitive Use of Foot Control					
A. Right Foot Only					
B. Left Foot Only					
C. Both Feet					
13. Repetitive Use of Hands					
A. Right Hand Only					
B. Left Hand Only					
C. Both Hands					

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
14. Grasping					
A. Simple/Light					
1. Right Hand Only					
2. Left Hand Only					
3. Both Hands					
B. Firm/Strong					
1. Right Hand Only					
2. Left Hand Only					
3. Both Hands					
15. Fine Finger Dexterity					
A. Right Hand Only					
B. Left Hand Only					
C. Both Hands					
16. Use of Head and Neck in:					
A. Static Position					
B. Twisting					
C. Looking Up					
D. Looking Down					

	Never 0% Of Time	Occasionally 1-33% Of Time	Frequently 34-66% Of Time	Continually 67-100% Of Time
17. Lifting or carrying				
A. Up to 10 lbs				
B. 11 – 20 lbs				
C. 21 – 50 lbs				
D. 51 – 100 lbs				
E. 100 + lbs				
18. Frequency of Interpersonal Relationships Necessary to Perform the Job				
19. Frequency of Stressful Situations Necessary to Perform the Job				

In the course of performing the job, the employee is required to:

	Yes	No
20. Drive cars, trucks, forklifts and/or other equipment		
21. Be around moving equipment and/or machinery		
22. Walk on uneven ground		

	Yes	No
23. Be exposed to dust, gas, or fumes		
if yes, are respirators required		
24. Be exposed to marked changes in temperature or humidity		
25. Is overtime required on a routine basis		

Continued on following page

Disability Claim Statement (Continued)

Name of Employee: _____ **Social Security Number:** _____

Fraud Warning:

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia – 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.

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 loss is subject to criminal and civil penalties.

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 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 the 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.

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

Kentucky – Any person who knowingly and with the 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Hampshire – A 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.

Oregon and Vermont – Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Fraud Warning *(continued)*:

Name of Employee:_____ **Social SecurityNumber:** _____

Fraud Warning *(continued)*:

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term 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.

Pennsylvania and all other states – 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 a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employer's Authorized Representative

Name_____ Title:_____ Phone #_____

Signature_____ Date:_____