CLAIMS FOR INCOME PROTECTION BENEFITS

Human Resources Management/Benefits
Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120

Liberty Mutual

Northeastern University
Human Resources Management

This form is to be completed for absences for medical reasons exceeding five days

For use with policies issued by the following Liberty Mutual Group subsidiary:

Liberty Life Assurance Company of Boston

Please mail or fax this form to:
Human Resources Management/Benefits
Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120
Phone: 617-373-5371
Fax: 617-373-7610

This form should be used for the following types of claims only:

- Interim Disability/Salary Continuation – To be completed for absences exceeding 5 days.

This form must be completed by the Attending Physician and the Employee, and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

The employee is responsible for completion of all portions of this form without expense to Northeastern University and the Liberty Mutual Group Subsidiary.

INSTRUCTIONS:

Attending Physician's Statement: This section must be completed by the physician primarily responsible for your care. Your physician will need to sign and date the form.

Employee Statement: This section must be completed by you, the employee. Please sign and date the bottom of the form.

Please enclose any additional information that you feel will assist us in evaluating this claim.

Liberty Mutual. INSURANCE

INCOME PROTECTION CLAIM

Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120

Northeastern University
Human Resources Management

ATTENDING PHYSICIAN'S STATEMENT

FAX to: 617-373-7610

PART A: TO BE COMPLETED BY EMPLOYEE

EMPLOYEE/CLAIMANT NAME:_____

S.S. NO.: _____-_____-_____

EMPLOYER/SPONSOR: _ Northeastern University_____ DATE OF BIRTH:_____

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder or its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, and persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by written notification to the Company in the Liberty Mutual group of companies to which I submit a claim and/or the Plan Sponsor.

Date

Claimant's Signature (or Authorized Representative)

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

PHYSICIAN'S INSTRUCTIONS

PLEASE NOTE: IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.

THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.

1. DIAGNOSIS
   Primary _____ ICD9 _____
   Secondary _____ ICD9 _____
   _____ ICD9 _____
   Has patient ever had the same or a similar condition? Yes _____ No_____
   If "Yes", state when and describe.

What is your prognosis?

For Pregnancy:
EDC _____ Date of Delivery _____ Type_____

2. DATES OF TREATMENT
   (a) Date of First Visit _____ (mo/day/yr)
   (b) Date of Last Visit _____ (mo/day/yr)
   (c) Frequency of Visits _____ Weekly _____ Monthly _____ Other (Specify)
   (d) Date of First Treatment _____ (mo/day/yr)
   (e) Date Symptoms First Appeared / Accident Occurred _____ (mo/day/yr)
   (f) Date Patient Advised to Cease Work _____
   (g) Estimated Return to Work Date _____
   (h) Actual Return to Work Date _____

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PART B, cont.: TO BE COMPLETED BY ATTENDING PHYSICIAN

3. Please describe in detail your PROPOSED TREATMENT PLAN. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan. IDENTIFY ANY RESTRICTIONS you have imposed on your patient at this time.

4. RESTRICTIONS (What the patient should not do)

5. LIMITATIONS (What the patient cannot do)

6. Date restrictions and/or limitations begin/end:

_____ to _____

7. Date of Next Scheduled Visit

Are you still treating the patient? ____ Yes ____ No

If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician? ____ Yes ____ No

8. Has patient been hospital confined? ____ Yes ____ No

Dates of Confinement: From _____ to _____

Was surgery performed? ____ Yes ____ No If "Yes", please indicate procedure(s) performed:

CPT Code: _____ Date Performed _____

Name and Address of Hospital:

9. REMARKS

Attending Physician's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID No.
Street Address	( ) Telephone No.	( ) Fax No.
City/State/Zip Code	Signature	Date

NOTICE TO EMPLOYEES AND HEALTHCARE 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, included an individual's family 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 tests, 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.

If you have any questions, please call Rachel Haney Benefits Administrator at 617-373-5371.

DISABILITY CLAIM FORM

Liberty Mutual. INSURANCE

Northeastern University
Human Resources Management

INCOME PROTECTION CLAIM
Northeastern University
716 Columbus Avenue, Suite 250
Boston, MA 02120

TO BE COMPLETED BY EMPLOYEE
(PLEASE COMPLETE ALL APPLICABLE SPACES)

Employee's Name			Employee's ID (NUID)
Street Address	City	State	Zip Code

Home Telephone No.	Work Telephone No.	Sex	Date of Birth
( )	( )	☐ M ☐ F	

Employer's Name Northeastern University

Treated By: (Please include all treating physicians; use additional paper if needed)

HOSPITAL _____
Name Street Address City/State/Zip Code

DOCTOR(S) Name: _____ Name: _____ Name: _____
Address: _____ Address: _____ Address: _____
Phone: _____ Phone: _____ Phone: _____

Date Injury / Illness Began	Date First Treated	Date Last Worked	Date Returned to Work

Have you or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No
If "Yes", then please explain:

Describe how and where injury occurred or describe the onset and nature of your illness. If maternity please include delivery date or expected delivery date.

Identify other income you are receiving or for which you have applied: Yes	No	Type	Amount per Week/Month	Date Began Receiving	Date Ceased Receiving	Date Income Applied for
☐	☐	Wages, Salary, or Separation Pay	$			
☐	☐	Social Security (disability or retirement)	$			
☐	☐	State Disability	$			
☐	☐	Retirement (normal, early, or disability)	$			
☐	☐	Workers' Compensation	$			
☐	☐	Group Disability	$			
☐	☐	No Fault Income	$			
☐	☐	Other (please describe) _____	$			

PLEASE REVIEW REVERSE SIDE

The information I have provided is true and complete to the best of my knowledge and belief. I agree that a Photostat copy of this form will be as valid as the original. I understand that any person who knowingly or with intent to injure, defraud, or deceive an insurance company, files a statement containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

EMPLOYEE SIGNATURE: _____ **DATE SIGNED:** _____

PLEASE READ CAREFULLY

CALIFORNIA EMPLOYEES: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO EMPLOYEES: 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 EMPLOYEES: It shall be a fraudulent insurance act for a person to knowingly, by act or omission, with intent to injure, defraud or deceive: prepare, present or cause to be presented to any insurer, any oral or written statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, containing false, incomplete or misleading information concerning any fact material to such claims.

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

KENTUCKY EMPLOYEES: I understand that 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

NEW YORK EMPLOYEES: 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 and the stated value of the claim for each such violation.

NORTH CAROLINA EMPLOYEES: Any person who with the intent to injure, defraud, or deceive an insurer or insurance claimant: presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or assists, abets, solicits or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning fact or matter material to the claim is guilty of a felony.

OHIO EMPLOYEES: I understand that any person who, with 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.

OKLAHOMA EMPLOYEES: I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

PENNSYLVANIA EMPLOYEES: 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.