

Disability Claim Form

CLAIMANT STATEMENT

Please provide full and complete responses, indicating "none" where applicable. If more space is needed, please attach another sheet. Incomplete information may delay claim. If this claim is on a Spouse Accident Only Disability Rider (W215), check here .

Name	First	Middle	Last	Policy no.
Address	Street address		City	State Zip code +4
Phone no.	Social Security no.		Date of birth MM/DD/YYYY	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
			05 /06 /1993	

Section I	1. <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Illness	2. Date of accident or when illness began	12 /27 /2024	3. Date last worked	12 /19 /2024	
	4. Have you returned to work?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If YES, when?			
	5. If injured, how and where did accident happen? (If accident occurred at work, please provide details and/or accident report.)					
	6. If illness, what is the nature?	Pregnancy				
	7. Have you filed or will you file a worker's compensation claim?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	8. Are premiums paid pre-tax?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	1. Please provide the names and addresses of all physicians who have been consulted for any condition during the last five years. Please include dates of consultation. All physicians treating claimant at the time of disability must complete Disability Claim Attending Physician's Statement.					
	Physician's Name	Complete Address	City	State	Zip code +4	

Physician's Name	Complete Address	City	State	Zip code +4
Phone no.	Fax no.	First visit	Last visit	Physician's statement provided?
			12 /25 /2024	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Physician's Name	Complete Address	City	State	Zip code +4
Phone no.	Fax no.	First visit	Last visit	Physician's statement provided?
()	()	07 /09 /2024	11 /11 /2024	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. List the name and complete address of any hospital/clinic where you received medical treatment, consultation, care or services (including diagnostic measures) during the last five years. If additional space is needed, attach a separate sheet of paper.				
Name of hospital/clinic	Complete address (include city, state and zip code)			Date(s) confined

3. List all prescription drugs taken for all reasons during the last five years. If additional space is needed, attach a separate sheet of paper.				
Name of drug or medicine	Prescription no.	Pharmacy	First date used	Prescribing physician
			/ /	
			/ /	

4. Please provide the complete address of any pharmacy listed in question #3. If additional space is needed, attach a separate sheet of paper.				
Name of pharmacy	Complete address (include city, state and zip code)			Phone/Fax no. (include area code)
				/
				/

5. Please provide the name(s) of all your disability carrier(s), their complete addresses and your policy number.				
Name of disability carrier	Complete address (include city, state and zip code)	Phone no.	Policy/Med. record no.	
A				

Continue to page 2 of this form.

Policy/Certificate no.(s)**Claimant's Name** XXXXXXXXXX

Section IV	Check if you are receiving or are eligible to receive benefits from any of the following sources:				
	<input type="checkbox"/> Salary, wages or commissions	<input type="checkbox"/> Retirement or pension plan	<input type="checkbox"/> Railroad Retirement act	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Other sources
	<input type="checkbox"/> State Disability	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Social Security Retirement		
	For each source marked above, please provide us with the following information:				
	Source	Income benefit amount	Income benefit frequency	Date Application Filed	Benefit Effective Date
				/ /	/ /
				/ /	/ /
				/ /	/ /
	Provide documentation of any source indicated above, i.e., award notice, denial notices or applications.				
	Job title XXXXXXXXXX	Employer NP Health Care Clinic			
	Business Address 555 A Highway 1 North	Phone no. 602-222-2222			
	Earnings: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input checked="" type="checkbox"/> Hourly <u>12.00</u>	Time employed in this occupation <u>5 years</u>			
	Average number of hours worked per week <u>40</u>	Time employed with this employer <u>5 years</u>			
	Please list your normal duties below in order of importance. (Attach second sheet if additional space is necessary.)				
Section V	Duty	Description			Percent of time spent
	Office receptionist	Greeting patients, answering phone, taking vitals signs			100%
	Phlebotomy	Draw blood, send labs, receive results			100%
	Clean	Empty the trashes, sweep and mop the floors, wipe everything down			100%
1. What percentage of your time is spent on:	Heavy labor <u>0</u> %	Light labor <u>100</u> %	Administration <u>100</u> %		
	Travel <u>5</u> %	Supervisory <u>0</u> %	Clerical <u>100</u> %		
2. What are the physical requirements of this job?	<u>Able to perform phlebotomy correctly</u>				
	<u>Able to move around in order to show patient where the rooms are and perform different tasks in the room</u>				
3. Do you have any other occupations? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, describe _____					
4. Please list all job duties you are unable to perform due to your disability	_____				

FRAUD NOTICES**Unless specific state language is provided below for your state of residence, the following general fraud notice applies.**

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FRAUD NOTICES (continued)

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VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.

1/22/2025

Date (MM/DD/YYYY)

Signature of claimant or legal representative

Vanessa Taylor

Printed name of person completing this form

**Disability Claim Form
ATTENDING PHYSICIAN'S
STATEMENT**

This form should be completed by all physicians who were treating the claimant during the time of disability. The patient is responsible for the completion of this form without expense to Assurity Life. Please print or type. If necessary add a separate sheet. Direct any questions to our claims department at the phone numbers shown above.

A. General Information

Patient's Name (First, Middle, Last)	Policy No.	Date of Birth (MM/DD/YYYY)
		/ /

Primary Diagnosis including ICD 9 or DSM Code

B. Complete this section for all conditions

Symptoms

Objective Findings

Are there secondary conditions contributing to the patient's inability to work? Yes No If YES, what are they?

When did symptoms first appear?	Date of patient's first visit (MM/DD/YYYY)	Date of the patient's last visit (MM/DD/YYYY)
---------------------------------	--	---

How often do you treat/consult the patient?	Date you believe the patient was first unable to work (MM/DD/YYYY)
---	--

Was patient referred to you? Referring physician's name <input type="checkbox"/> Yes <input type="checkbox"/> No	Street address	City	State	Zip+4
---	----------------	------	-------	-------

Is the patient's condition work related? Yes No If YES, please explain:Has the patient undergone surgery? Yes No If YES, please give date, procedure and result:If no, do you expect surgery to be performed in the future? Yes No If YES, please give date and type of surgery:

What medications is the patient currently taking? (Please list frequency and dosages.)

Please indicate other types and frequencies of treatment:

Has the patient been referred to a medical rehabilitation or therapy program? Yes No If YES, please give details:Have you referred the patient for other types of consultations? Yes No If YES, please give details:Has the patient been hospital confined? Yes No If YES, complete the following:

Name of hospital	Street address	City	State	Zip+4
------------------	----------------	------	-------	-------

MM/DD/YYYY

MM/DD/YYYY

Confined: ____ / ____ through ____ / ____ Admission time _____ Dismissal time _____

Continue to page 2 of this form.

Policy/Certificate no.(s)**Claimant's Name**

Indicate class of mental impairment (if applicable): Class 1-No limitation Class 2-Slight limitation Class 3-Moderate limitation
 Class 4-Marked limitation Class 5-Severe limitation

What is the patient's current DSM-IV-R diagnosis? Axis I _____ Axis II _____
 Axis III _____ Axis IV _____ Axis V _____

Do you believe this patient is competent to endorse checks/direct the use of proceeds? Yes No

C. Complete this section for pregnancy

MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
Date of the last menstrual period	/ /	First date of treatment	/ /	Expected due date	/ /

Date of delivery _____ / / (MM/DD/YYYY) This delivery is expected to be or was: Vaginal C-Section

Are there any present complications or anticipated difficulties in connection with:

a. Pregnancy Yes No b. Delivery Yes No c. Post partum Yes No

If YES, to any of the above, please specify in detail: _____

D. Information about the patient's inability to work. Complete this section for all conditions.

Briefly describe restrictions (What the patient SHOULD NOT do):

Briefly describe limitations (What the patient CANNOT do):

When was/is the patient able to return to work? Full-time _____ / / (MM/DD/YYYY) Part-time _____ / / (MM/DD/YYYY)

Does the patient's condition prevent being able to perform self care? Yes No If NO, please complete the following:

How soon do you expect fundamental changes in the patient's medical condition? 1-2 mos. 3-4 mos. 5-6 mos. 6 + mos.

Give details concerning expected improvement or deterioration:

Additional remarks:

E. Physician Information

Attending physician, please print

Physician's name	Degree		
Phone no. ()	Fax no. ()	Specialty	
Street address	City	State	Zip+4

Physician's address

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I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

Physician's Signature (no stamp)

Date (MM/DD/YYYY)

TIN or Social Security No.

Disability Claim Form EMPLOYER STATEMENT

To be completed by employer. Please print or type. If necessary, add separate sheet.

Direct any questions to our claims department at the phone numbers and address shown above.

Employer name		Policy/Certificate no.(s)		
Employer address Street address		City	State	Zip code + 4
Name of Employee	First	Middle	Last	Date employed MM/DD/YYYY / /
Occupation				Employee's first payroll deduction MM/DD/YYYY / /
Employee's primary job duties <i>Attach written job description if available</i>				
1. Reason for stopping work: <input type="checkbox"/> Dismissal/Termination <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Resignation <input type="checkbox"/> Retirement <input type="checkbox"/> Layoff				
If dismissed/terminated, date employment ceased		/ /	Date insurance terminated / /	
2. If disabled, date last worked		/ /	Work schedule at that time:	Days per week / Hours per day /
3. If employee ceased work due to accident or illness, was the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed If YES, or under dispute, please provide us with the policy no., name, address and phone no. of Workers' Compensation administrator.				
Has employee filed for Workers' Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Was employee covered under your prior disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Carrier name _____ Effective date / / Termination date under prior plan / / Prior coverage amount _____				
5. Has the employee been offered Short-term Disability (STD) or Long-term Disability (LTD) coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide name of carrier _____				
6. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full-time return date / / <input type="checkbox"/> Part-time return date / / Hours per week _____				
Will you provide "light duty" if employee is released with restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If employee has not returned to work, approximate return to work date / /				
7. Annual salary \$ _____		Hourly wage \$ _____	Monthly commissions/overtime \$ _____	
Basic gross monthly earnings \$ _____		Net monthly earnings \$ _____		
8. Premium contribution percentage: Employer _____ % Employee _____ %				
If employee contributes toward the cost of disability coverage, please indicate <input type="checkbox"/> before or <input type="checkbox"/> after income is taxed.				

IMPORTANT: Pages 2 and 3 must be completed and submitted with page 1.

Policy/Certificate no.(s) _____ **Claimant's Name** _____

9. To the best of your knowledge, is the employee receiving or eligible to receive benefits from any of the following sources?

<input type="checkbox"/> Salary continuance	Amount \$ _____	per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Short-term Disability (STD)	Amount \$ _____	per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Long-term Disability (LTD)	Amount \$ _____	per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Workers' Compensation	Amount \$ _____	per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Retirement or pension	Amount \$ _____	per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> _____	Lump sum distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No		

10. Remarks

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OH RESIDENTS: 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.

OK RESIDENTS: 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.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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.

VA RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.

Signed at _____
 City _____ State _____

on _____ / _____ / _____
 Date (MM/DD/YYYY)

Employer Authorized Representative's Signature

Representative's Printed Name and Title

() / ()
 Office Phone no. and Fax no. (please include area code)

Office E-mail Address

**Confidential Information
Authorization**

Vanessa Taylor

05 / 06 / 1993

Legal Name of Applicant/Insured/Claimant (Please print)

Date of Birth (MM/DD/YYYY)

Legal Name of Additional Applicant/Insured/Claimant (Please print)

Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name

Date of Birth

Legal Name

Date of Birth

_____	_____	_____	_____
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This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

1/22/2025

Date (MM/DD/YYYY)

Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signed by:

(HIPAA) Privacy Rule

Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which individual is represented)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT