

Voluntary Benefits – Disability Income Claim Form

Claimant Initial Statement of Disability

CLAIMANT INFORMATION

Policy Number	Social Security #	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Claimant Name (First) (Middle) (Last)	Age	Date of Birth (mm/dd/yy)
Home Address (Street) (City) (State) (Zip)		
Have you moved since your Policy Application? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," is the above address your new address? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Home Telephone No.	Cell Telephone No.	Email Address
Employer Name	Employer Address	Employer Telephone No.

CLAIMANT DATES OF DISABILITY AND WORK STATUS

Have you been <u>continuously totally</u> disabled? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No," have you been <u>continuously partially</u> disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>		
I became disabled on (mm/dd/yy)	My last date of work was (mm/dd/yy)	I worked on that day Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you since worked for wages or profit? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," give dates to		
Have you returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," indicate date (mm/dd/yy) Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>		
If you have not returned to work, when do you expect to return? If unknown, indicate estimate		

INFORMATION ABOUT THE CONDITION(S) CAUSING YOUR DISABILITY

What is the condition causing your disability?	What date did your symptoms first appear?
Describe your symptoms.	Date you were first treated by a physician for this condition
Prior to this disability claim, did you receive a diagnosis, medical care, including hospitalization, treatment, surgery, or advice and recommendation for the condition on this claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please explain.	
Is your condition or injury related to your employment? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," please explain.	
Have you filed a Workers' Compensation Claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No," do you intend to file a Workers' Compensation Claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If your claim was approved or denied by the Workers' Compensation carrier, please provide a copy of the approval or denial letter along with your disability claim.	

FOR AN INJURY OR ACCIDENT, ANSWER THE FOLLOWING QUESTIONS

How and where did the injury/accident occur?

Is it Auto related? Yes No

Date the accident occurred

Date you were first treated by a physician or other provider

FOR PREGNANCY, ANSWER THE FOLLOWING QUESTIONS

What is your expected delivery date?

Have you delivered? Yes No

If "Yes," date of delivery

Type of delivery Normal C-Section

a) Were there any complications causing you to stop work prior to your expected delivery date? Yes No

b) Were there any post-delivery complications? Yes No

c) If "Yes" to either question, please explain.

INFORMATION ABOUT TREATING PROVIDER(S)

Provide the following information on all your medical treatment providers (physician, hospital, therapists, etc.) for this disability, including any referring physician and specialist. If needed, attach a separate sheet of paper.

(1) Provider Name

Address

Specialty

Fax No.

Telephone No.

Date of first visit for this condition (mm/dd/yy)

Date of most recent visit for this condition (mm/dd/yy)

(2) Provider Name

Address

Specialty

Fax No.

Telephone No.

Date of first visit for this condition (mm/dd/yy)

Date of most recent visit for this condition (mm/dd/yy)

Please list any hospital admissions, surgery, or treatment that you have had in the past 12 months, along with the diagnosis.

Type of Service

Provider/Facility name

Date(s) of service

Diagnosis

Provide a short written summary on your history of illness/injury, past medical history, examination results, lab results, diagnosis, prognosis, medical recommendations and any treatment dates or surgery not mentioned above.

WORK INFORMATION

What was your occupation when disability commenced and what were the usual duties of your occupation? (Please attach your Job Description.)

Which of the above job duties are you unable to perform?

Have you discussed returning to work or commencing a vocational program with your doctor? Yes No

Have you asked your employer to provide any accommodations which would allow you to return to work? Yes No
If "Yes," what accommodations did you request and what was your employer response?

Describe your return to work goals.

OTHER INSURANCE

Do you have disability insurance other than insurance provided by Amalgamated Life Insurance Company? Yes No

If "Yes," indicate type of coverage and name of policy or insurer.

FRAUD WARNING

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.

For residents in the following states, please see the last page of this form. Alabama, Alaska, Arizona, California, Colorado, Delaware, District of Columbia, Florida, Idaho, Indiana, Kentucky, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Virginia and Washington.

CLAIMANT CERTIFICATION

I HEREBY CLAIM DISABILITY AND CERTIFY THAT FOR THE PERIOD COVERED BY THE CLAIM I WAS DISABLED; AND THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.

Claimant Name (Print)

Signature

Date

▶ _____

IF I RECEIVE A DISABILITY BENEFIT GREATER THAN THAT WHICH I SHOULD HAVE BEEN PAID, I UNDERSTAND THAT AMALGAMATED LIFE INSURANCE COMPANY HAS THE RIGHT TO RECOVER SUCH OVERPAYMENTS FROM ME, INCLUDING THE RIGHTS TO REDUCE OR ADJUST FUTURE BENEFITS, IF ANY.

Claimant Name (Print)

Signature

Date

▶ _____

AUTHORIZATION TO RELEASE INFORMATION

Read, sign and date the Authorization for Release of Health Care Information Pursuant to HIPAA on page 5, and provide a copy to your treating physician. Submit a copy to Amalgamated Life Insurance Company along with your claim.

Alabama Residents: 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 restitution, fines and confinement in prison, or any combination thereof.

Maine, Tennessee and Washington Residents: 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.

Delaware, Idaho and Indiana Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Alaska Residents: 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 the law.

Arizona Residents: 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.

California Residents: 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 Residents: 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 Department of Regulatory Agencies – Division of Insurance.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an 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 Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer 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 Residents: 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.

Maryland Residents: 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.

Minnesota Residents: 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 Residents: Any person who, with a purpose to injure 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 N.H. Rev. Stat. Ann. §638.20.

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

New York 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 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.

Ohio Residents: Any person who, with intent to defraud or knowingly 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 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.

Oregon 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement 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.

Texas Residents: 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.

Virginia Residents: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or fraudulent statement may have violated state law.



Amalgamated Life Insurance Company
 Disability Benefits Claim Department
 P.O. Box 5453, White Plains, NY 10602-5453
 Toll-Free: 1-866-975-4089 / Fax: 1-914-367-4114

Voluntary Benefits – Disability Income
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name (First) (Middle) (Last)	Social Security #
Address	Date of Birth (mm/dd/yy)

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, I understand the following:

I hereby give permission and authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; and employer that has information about my health, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer and evaluate claims for Amalgamated Life Insurance Company, including Alicare Medical Management (AMM), an affiliate of Amalgamated Life Insurance Company.

This authorization may include disclosure of information relating to: Alcohol and Drug abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, only if I place my initials on the appropriate item below. In the event the health information described below includes any of these types of information, and I initial the line on the box in the item below, I specifically authorize release of such information to Amalgamated Life Insurance Company, including Alicare Medical Management (AMM), an affiliate of Amalgamated Life Insurance Company.

IMPORTANT – Please complete the check boxes below even if the categories should not necessarily apply to the patient's medical records.

Do **Do Not** want information about Mental Health released _____ (initial)

Do **Do Not** want information about HIV Tests & Related Information released _____ (initial)

Do **Do Not** want information about Alcohol and/or Substance Abuse released _____ (initial)

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization.

I understand that any information Amalgamated Life or AMM obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for disability benefits, which may include assisting me in returning to work. I further understand that authorized recipients to my medical information may, in certain instances, have the right to redisclose my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, if I do not authorize release of my medical information, this may result in Amalgamated Life not being able to process my claim.

I have the right to revoke this Authorization at any time by providing written notice of revocation to Amalgamated Life Insurance Company. I am aware that my revocation will not be effective until received by Amalgamated Life, and will not be effective regarding the uses and/or disclosures of my "Information" that has been made prior to receipt of my revocation. This authorization is valid for one year from the date below or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than Amalgamated Life Insurance Company or AMM.

_____ Patient's Signature or representative authorized by law	_____ Date
If other than patient: I signed on behalf of the patient as _____ (relationship). If Power of Attorney Designee, Guardian, Conservator, please attach a copy of document granting authority.	

Voluntary Benefits – Disability Income Claim Form
Attending Physician’s Initial Statement of Disability

CLAIMANT INFORMATION – To be Completed by the Claimant/Patient

Policy Number	Social Security #	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Claimant/Patient Name (First) (Middle) (Last)	Age	Date of Birth (mm/dd/yy)
Home Address (Street) (City) (State) (Zip)		

ATTENDING PHYSICIAN STATEMENT

Is patient continuously totally disabled? Yes No If “No,” is patient continuously partially disabled? Yes No

Date patient became totally disabled _____ Did you advise patient to stop working? Yes No If Yes, date _____

If applicable, date patient became partially disabled _____ Explain reason for partial disability. _____

CONDITION AND DIAGNOSIS

Is disability due to sickness? Yes No If Yes, date symptoms first appeared _____

Is disability due to accident or injury? Yes No If Yes, date of accident or injury _____

Primary diagnosis causing disability	ICD Code
Secondary diagnosis if impacting disability	ICD Code

Description of condition or complications: _____

Is the condition related to the patient’s employment? Yes No
If Yes, explain how it is work-related: _____

Is the condition related to an automobile accident? Yes No If Yes, date of accident _____

To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment advice or recommendations for this condition prior to this onset of disability? Yes No
If Yes, provide information: _____

Was this patient referred to you? Yes No If Yes, provide name, specialty, address, and telephone number of referring physician(s).

<u>Name</u>	<u>Specialty</u>	<u>Address</u>	<u>Phone No.</u>

TREATMENT INFORMATION

Date you first attended patient for this disability

Date you last attended patient

Other treatment dates for this disability

Frequency of visits Weekly Monthly Other

If Other, specify

If patient has been hospitalized for this disability, provide reason for admission and dates.

If surgery was or will be performed, provide type of surgery and date(s).

Advise all medications prescribed

Describe present treatment plan

Prognosis Terminal Poor Good Excellent

Has patient reached maximum improvement Yes No

If No, estimate when

Is patient a candidate for cardiac, physical or vocational rehabilitation? Yes No

Has rehabilitation been recommended? Yes No

If Yes, has patient complied? Yes No

MATERNITY (If Applicable)

Is this disability due to pregnancy Yes No

EDC

Expected delivery date

If delivered, date

Normal

C-section

(a) If disability is prior to delivery, what are the complicating factors (be specific)

(b) Were there any post-delivery complications? Yes No

If Yes, please explain:

PSYCHIATRIC IMPAIRMENT (If Applicable)

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 only limited 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

Please define **stress** as it applies to this patient.

CARDIAC (If Applicable)

Functional Capacity (American Heart Association)

Class 1 (*No limitation*)

Class 2 (*Slight limitation*)

Class 3 (*Marked limitation*)

Class 4 (*Complete limitation*)

Blood pressure (*latest reading*) / as of date

Is patient in a cardiac rehabilitation program? Yes No

PHYSICAL RESTRICTIONS AND FUNCTIONAL CAPACITY

Physical restrictions/limitations (as defined in the 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 – Light 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%)

Describe the patient's restrictions/limitations.

WORK CAPABILITIES

Have you reviewed the patient's job description? Yes No

Would job modification enable patient to work with impairment? Yes No

Will patient recover sufficiently to perform the essential duties of his/her regular occupation? Yes No

Do you know if patient has returned to work? Yes No If Yes, date _____

Has or will patient recover to return to work as indicated below:

Regular occupation, full-time?	<input type="checkbox"/> Yes	What date _____	<input type="checkbox"/> No	Estimate _____
Regular occupation, part-time?	<input type="checkbox"/> Yes	What date _____	<input type="checkbox"/> No	Estimate _____
Any other occupation, full-time?	<input type="checkbox"/> Yes	What date _____	<input type="checkbox"/> No	Estimate _____
Any other occupation, part-time?	<input type="checkbox"/> Yes	What date _____	<input type="checkbox"/> No	Estimate _____

CONFIRMATION OF DISABILITY

Certify the period that patient is/was continuously Totally Disabled From _____ Through _____

Certify the period that patient is/was continuously Partially Disabled From _____ Through _____

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PHYSICIAN INFORMATION AND SIGNATURE

Physician's name (print) _____ Degree/Specialty _____

Street address _____ City _____ State _____ Zip _____

Telephone no. (_____) _____ Fax no. (_____) _____

► Signature _____ Date _____

Do Not Pre-Date

Physician's EIN or SSN _____

(The patient must pay for any costs for completion of this form)

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