

Group Disability Income Claim

Statements to be completed as follows:

- Part A — Completed by Claimant
- Part B — Completed by Claimant's Employer
- Part C — Completed by Claimant's Attending Physician

Answer all questions completely to avoid any delays in processing. Report must be furnished without expense to the company.
Return this completed form to your Employer.

Part A Claimant's Statement

Employer Name (please print) _____

Claimant full name (please print) _____ Birth date ___/___/___

Social Security Number _____ - _____ - _____ Gender: male female Left-Handed Right-Handed

Street address _____ City/State/Zip _____

Phone Number _____ Cell Phone Number _____

Describe your occupation and job duties _____

Basic Salary: Weekly _____ Monthly _____ Other sources of Income: _____

If injury, when did injury occur? Date ___/___/___ Time _____ a.m. p.m.

Did injury happen at work? yes no Have you applied for Worker's Compensation? yes no

Have you been approved for Worker's Compensation? yes no

How did injury happen? _____

Describe injury _____

If illness, describe nature of illness _____

What are your symptoms? _____

Is illness work related? yes no When did illness begin? ___/___/___

When were you first treated by a Physician for this illness or injury? ___/___/___

What was the Physician's diagnosis? _____

Physician's name, address, phone and fax numbers (do not complete if information is the same as in Part C of this form)

When were you first prevented from working because of this illness or injury? ___/___/___

Last work date? ___/___/___ Date you ceased work entirely? Date ___/___/___ Time _____ a.m. p.m.

If you are currently working, date when were you first able to do any part of your job:

Part time: _____ Full time: _____

If you are currently disabled, when do you expect to return to work? ___/___/___

Have you been hospitalized? yes no If 'yes,' as an inpatient or outpatient? inpatient outpatient both

Hospitalized from ___/___/___ to ___/___/___

Hospital name _____

Hospital address _____

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health, to give The Baltimore Life Insurance Company or its representative(s) any such information.

I agree to reimburse The Baltimore Life Insurance Company the amount of any overpayment made on a claim hereunder if I receive any benefits under Worker's Compensation, Social Security or any other legislation on account of my disability.

Claimant Signature _____ Date ___/___/___

The Baltimore Life Insurance Company c/o Health Reinsurance Management Partnership
5 Hutchinson Drive • Danvers, Massachusetts 01923 • phone 866.263.9333 • fax 978.762.4767

Part B Employer's Statement

Group Policy Number _____ Check one: Voluntary Group Employer-Paid True Group

Product Type (check only one): Short-Term Disability Long-Term Disability

Employee name _____ Occupation _____ hourly salary

Hours worked per week _____

Compensation Amount \$ _____ Frequency: Hourly Weekly Monthly Annually Other

Employment date ____/____/____ Insurance effective date ____/____/____

Income other than salary? yes no

If yes, source: a) Salary Continuation/Sick Pay Amount: _____ Dates - Beginning: _____ End: _____
b) State Disability Amount: _____ Dates - Beginning: _____ End: _____
c) Worker's Compensation Amount: _____ Dates - Beginning: _____ End: _____
d) Other Amount: _____ Dates - Beginning: _____ End: _____

Class _____ Was the employee actively at work on the effective date of coverage? yes no

Was Evidence of Insurability required? yes no

If coverage has been cancelled, provide... Date ____/____/____ Reason _____

Employer's insurance classifications provide for: _____ Benefits of \$ _____ for _____ weeks

Waiting period of _____ days for accident Waiting period of _____ days for illness

Employer's contribution to premium: _____% Other: _____

Section 125 Cafeteria Plan yes no

Date Employee last worked ____/____/____ Reason for stopping work _____

Has employee returned to work? yes no If no, anticipated date of return: ____/____/____

If yes, date employee returned to work ____/____/____

Is this disability due in any way to a condition arising out of the employee's occupation? yes no

If 'yes,' explain _____

Provide any information which may assist the Company in the consideration of this claim _____

Describe Employee's job duties _____

Policyholder _____ Telephone Number _____

Street address _____ City/State/Zip _____

By (signature of authorized insurance representative) _____ Title _____

Printed name of authorized insurance representative _____ Date ____/____/____

Part C Attending Physician's Statement

Diagnosis and concurrent conditions (if diagnosis code used is other than an ICD9* code, provide diagnosis name)

Current Disability Condition: _____

Is this disability due in any way to a condition arising out of the Claimant's occupation? yes no

If 'yes,' explain _____

Pregnancy? yes no If pregnant, estimated delivery date ____/____/____

If delivered, actual delivery date ____/____/____

Height: _____ Weight: _____

Medications:	Name	Frequency	Dosage
	_____	_____	_____
	_____	_____	_____

List dates of service (if previous forms submitted to this carrier, show only dates since last report)

____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

Was patient referred to you by another physician? yes no

If yes, please provide name of referring physician: _____

When did symptoms first appear or when did accident occur? ____/____/____

When did Claimant first consult you for this condition? ____/____/____

Has Claimant ever had the same or a similar condition? yes no When? ____/____/____

If 'yes,' provide details _____

Is Claimant still under your care for this condition? yes no

Claimant was continuously and totally disabled (unable to work) from ____/____/____ through ____/____/____

Claimant was partially disabled from ____/____/____ through ____/____/____

If Claimant is still disabled, when will Claimant be able to return to work (approximate, if necessary)? ____/____/____

Describe patient's current restrictions: _____

Describe patient's current limitations: _____

Objective findings: _____

Subjective Symptoms: _____

Attending Physician Name (please print) _____ Date ____/____/____

Attending Physician Address: _____

Attending Physician Signature _____

Degree: _____ Telephone _____ Fax _____

*ICD9 — International Classification of Diseases

FRAUD WARNINGS

Alaska: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arkansas: 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.

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: Warning - 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.

DC: 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.

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

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

Indiana: A person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Kansas: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: 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.

Louisiana: 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.

Maine: 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.

Minnesota: 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: Any 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.

New Mexico: 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 civil fines and criminal penalties.

Ohio: 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: 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.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.