

Please check the box next to your insurance company's name:

Central United Life Insurance Investors Consolidated Insurance Company First Unum Unum The Manhattan Life Insurance Company

INDIVIDUAL DISABILITY NOTICE OF CLAIM

How To File A Claim

1. Complete Part I of this form. WE CANNOT PROCESS YOUR CLAIM WITHOUT A COMPLETED FORM.
2. Have your employer complete Part II of the form.
3. Have your attending physician complete Part III of the form.
4. When all sections of this form have been completed, submit the form to the address below.
5. If you have any questions, call us at: 1-800-669-9030.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Policy Number: _____

I, _____, hereby authorize _____'s designated medical custodians or database custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the person(s) or organization(s):

Name of Person(s) or Organization(s):

(Company Name)

P.O. Box 925309
Houston, TX 77292-5309

I specifically authorize the use and disclosure of the following PHI:

(Specifically describe the protected health information to be disclosed. Include meaningful descriptors such as date of service, type of service provided, level of detail to be released, etc.)

This protected health information is being used or disclosed to carry out treatment, payment, and/or the _____'s internal operations in the following manner:

(Specifically describe how protected health information will be used to carry out treatment, payment, or the company's internal operations purposes.)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand and agree that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notice to the company. A revocation is not effective except to the extent that the company has relied on the use or disclosure of the PHI (protected health information).
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The company will not condition my treatment, payment, and enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
- I have the right to refuse to sign this authorization form.

Signature

Date

Description of Personal Representative's Authority

INDIVIDUAL DISABILITY CLAIM FORM

Name of Insured	Policy Number	Date of Birth	Home Telephone
Home Address (Street, City, State, Zip)		<input type="checkbox"/> Please Check if this is a change of address	
Name of Employer	Business Telephone	Social Security #	
Business Address		Monthly Gross Earned Income \$	

Please check any and all benefits that you are eligible to receive

	Applied		Receiving		Policy No.	Date Applied For	Amount Received		Effective Date
	Yes	No	Yes	No			Weekly	Monthly	
A. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
B. State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
C. Retirement or Pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
D. Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
E. Salary Continuation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
F. Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
G. Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____

Date of your accident or the date you first noticed the symptoms of your illness:	Date you last worked:	I returned to work on a part-time basis on:	I returned to work on a full time basis on:
Month Day Year	Month Day Year	Month Day Year	Month Day Year
		<input type="checkbox"/> Have not returned yet	<input type="checkbox"/> Have not returned yet

Describe your disability and its cause. If accidental, please provide complete accident details including how, where, when, etc.

Are you covered by Workers Compensation for this disability? Yes No

List all physicians or other practitioners consulted for this condition. (Use additional pages if needed.)

Name	Address	Dates Consulted
_____	_____	_____
_____	_____	_____

List ALL physicians or practitioners consulted FOR ALL CONDITIONS in the past five (5) years. (Use additional pages if needed.)

Name	Address	Dates Consulted	Reason for Consultation
_____	_____	_____	_____
_____	_____	_____	_____

List ALL hospital confinements FOR ALL CONDITIONS in the past five (5) years. (Use additional pages if needed.)

Name	Address	From	To	Reason Confined
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

The Statements in this form are true and complete to the best of my knowledge.

Signature (Insured) _____ Date _____

NO FAXED OR COPIED CLAIMS ACCEPTED

OCCUPATIONAL INFORMATION

What was your occupation immediately prior to the date you became disabled? _____

List all duties of the occupation noted above.

(Failure to be specific may result in a delay in the processing of your claim.)

Description of Each Duty	Weekly % of Time Devoted to this Activity	Weekly Hours Spent at this Activity

Describe briefly which of these duties you are unable to perform as a result of your sickness or accident, and why.

Describe briefly your prior work experience and education.

TO BE COMPLETED BY THE EMPLOYER (if retired, by the former employer):

1. Employer Name _____

Address _____

_____ Zip _____

2. Employer's Phone # (_____) _____ Worker's Compensation Claim Filed? _____

3. Name, Address, and Telephone Number of Compensation Carrier: _____

4. Between what dates did employee give up all duties due to **TOTAL DISABILITY**:

From _____ To _____

Date _____ Title _____ Signature _____

Name of Previous Disability Insurer: _____

Effective Date: _____ Term Date: _____

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.

The Statements in this form are true and complete to the best of my knowledge.

Signature (Insured)

Date

NO FAXED OR COPIED CLAIMS ACCEPTED

ATTENDING PHYSICIAN'S INITIAL REPORT

Please print all entries. This form is to be completed without expense to the company.

Name of Patient (last, first, middle initial) _____	Was patient referred by another physician? <input type="checkbox"/> Yes Name _____ <input type="checkbox"/> No Address _____
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DIAGNOSIS: (If psychiatric in origin, please indicate DSM III code and axis.) _____

What limitations are there on your patient's ability to perform his or her job duties? _____	Date Restrictions Began _____ Mo. Day Year
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When do you expect that these limitations/restrictions will allow your patient to return to work?

When were you first consulted for this condition? _____ Mo. Day Year	How did this condition develop? _____
--	--

Any previous occurrences of this condition or similar conditions? If so, please provide dates and details:

Dates of all other visits to your office: _____	Is patient currently being treated by any other practitioner or therapist? <input type="checkbox"/> Yes Name _____ <input type="checkbox"/> No Address _____
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How long was or will patient be Continuously Totally Disabled?
EXACT Start Date _____ TO _____

How long was or will patient be Partially Disabled?
EXACT Start Date _____ TO _____

Name and address of hospitals and dates of confinement:

Describe past treatment for this condition, including any surgical procedures:

Describe course of treatment to be followed; including surgery _____	Is patient still under your care? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain: _____
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Please list other disability insurers to whom you are providing information on this patient.

Does your patient have any chronic or recurring condition(s) not noted above? Please provide details:

Remarks or Additional Comments:

Name of Attending Physician (please print), Degree Code _____ Telephone No. _____

Address (Street or P.O. Box, City, State, Zip) _____ Tax Payer I.D. No. _____

Signature of Physician _____ Date _____