



**SECURITY MUTUAL LIFE**

Return to: Plan Administration, Ltd.

580 Hazard Avenue

Enfield, CT 06082

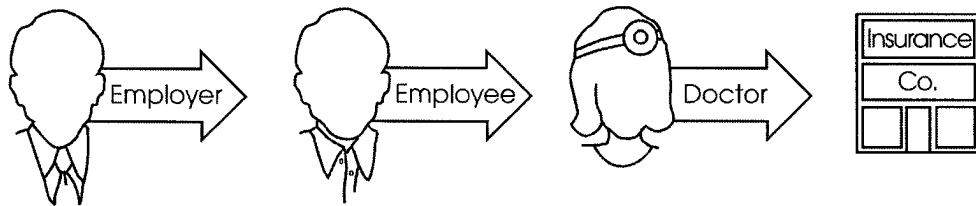
*Group Division*

Phone: 860-272-1135

Fax: 860-272-1136

# Group Long Term Disability **CLAIM**

## POLICYHOLDER CERTIFICATION



### EMPLOYER — *form completion information*

#### NOTICE OF CLAIM — Instructions

At approximately 30 days before end of elimination period:

A. **Complete** the Employer's Report of Claim Form.

- INCLUDE**
- Job description (detailed duties)
  - Copy of enrollment card (if employee contributes to premium)
  - Copy of approved medical evidence of insurability if required at time of enrollment
  - Documentation of earnings if other than straight salary
  - If Workers' Compensation claim filed, include copy of First Report of Accident and the decision

B. Provide claimant with the accompanying Claim Application Forms: **Application for Group LTD - Instructions**  
**Employee's Authorization for Release of Information**  
**Employee's Disability Benefits Application**  
**Attending Physician's Statement\*\***

- REQUEST**
- Birth certificate (short duration claim and under age 50 not necessary at this time)
  - Copy of awards from other source of benefits: Social Security, Workers' Comp., retirement, state disability, others

C. **All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.**

**\*\*If claimant has more than one treating physician, provide claimant with additional Attending Physician's Statement forms**

**EMPLOYER'S REPORT OF CLAIM**

**TO BE COMPLETED BY EMPLOYER**

CLAIMANT	1. Employee's Name		2. Social Security No.	3. Date of Birth	
	4. Address _____ City _____ State _____ Zip Code _____				
EMPLOYMENT	5. Insurance Class	6. Employee Date of Hire	7. Date employee became Insured for LTD	8. Date employee was actually last present at work	
	9. Occupation at time last worked (attach job description)		10. Work schedule at time last worked No. of days _____ No. of hours _____ per week _____ per day _____		
	11. Reason for stopping: <input type="checkbox"/> Sickness <input type="checkbox"/> Granted LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Other <input type="checkbox"/> Resigned <input type="checkbox"/> Vacation		12. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time  <input type="checkbox"/> No      Date _____      Date _____		
INCOME	13. How is employee paid? <input type="checkbox"/> Straight Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Salary & Commissions <input type="checkbox"/> Commissions Only <input type="checkbox"/> Salary & Bonus		14. Employee's Basic <u>Monthly</u> Earnings \$ _____ LTD Benefit _____ (If salary is based on less than 12 mos. - No. of mos. _____ )		
	15. Employee's % of LTD premium contribution:  Employee pays _____      Employer pays _____				
OTHER BENEFITS	16. Has insured received other disability payments since time last worked?  Salary Continuance:      Insured Short Term:      Other Type: _____ <input type="checkbox"/> Yes    Wkly Amt. _____ <input type="checkbox"/> Yes    Wkly Amt. _____ <input type="checkbox"/> Yes    Wkly Amt. _____ Date benefits cease _____    Date benefits cease _____    Date benefits cease _____ <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No				
	17. Did claim result from job activity? <input type="checkbox"/> Yes (Explain) _____ <input type="checkbox"/> No	18. Has Workers' compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> Denied (Enc. copy)	19. Workers' compensation Wkly Amt. \$ _____ (Inc. copy of 1st report of accident)		
RETIREMENT	20. Is employee covered by employer sponsored retirement plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Does retirement plan contain a disability provision? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	22. Is employee or will this employee be eligible for a disability or retirement pension? <input type="checkbox"/> Yes    If "Yes" type: _____ <input type="checkbox"/> No		Monthly Amount \$ _____ <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____ Commence Date of Benefits: _____ (enclose copy of summary plan description)		
	<b>NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.</b>				
CERTIFICATION	23. Employer's Name (state association and name of policyholder, if other)		24. Telephone No.	25. Group Policy No.	
	26. Address _____				
	27. Employer (Taxpayer) I.D. Number (EIN) _____ - _____ OR		29. Name of person completing this form (please type or print)		
	28. Public Employer Social Security No. 69 _____ - _____				
30. Signature of Authorized Insurance Representative _____			Title _____	Date _____	

Send this form (with other enclosures) to address on reverse side. Give remaining portions of form to claimant for completion.

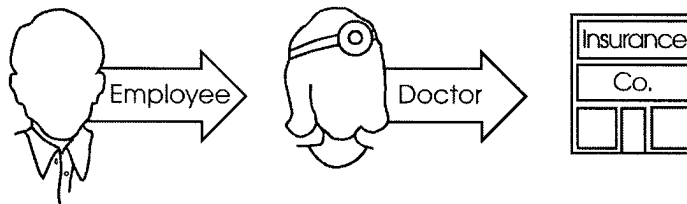


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*Group Division*

# Group Long Term Disability **CLAIM**

APPLICATION



## EMPLOYEE — *form completion information*

### Application for Group LTD - Instructions

- A. **Complete** and **Sign** the **Employee's Authorization for Release of Information**. This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments.
- B. **Complete Employee's Disability Benefits Application in FULL.**  
**ATTACH**
  - a copy of your birth certificate
  - a copy of Social Security and other income entitlement awards (or forward when received)
- C. **Give** the **Attending Physician's Statement**, **Employee's Authorization for Release of Information** and **Employee's Disability Benefits Application** to the physician treating you (if you have more than one physician, obtain additional **Attending Physician's Statements** from your employer). Instruct your attending physician to send all three forms to:  
Group Claims  
Security Mutual Life Insurance Company of New York  
P.O. Box 1625  
Binghamton, NY 13902-1625
- D. When the completed **Attending Physician's Statement**, **Employee's Authorization for Release of Information** and **Employee's Disability Benefits Application** are received by Security Mutual Life Insurance Company of New York, they will advise you on your eligibility for benefits or of any additional information that may be needed.

The Laws of some states require us to furnish you with the following notice:

Any person who knowingly and with the intent to defraud any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.



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## Group LTD CLAIM

### EMPLOYEE'S Authorization for Release of Information

#### Authorization - to be completed by employee

Policy No. \_\_\_\_\_

To Whom It May Concern:

I, \_\_\_\_\_  
(Claimant's Name) hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or Government Agency to disclose or furnish to SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK, its subsidiaries or representatives, any and all information with respect to any illness including mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK, its subsidiaries or representatives is to be used solely for the administration of claim(s) as captioned above. A photostatic copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

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.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Patient's (Claimant's) Signature

\_\_\_\_\_  
 Relationship of Authorized Person, if other

\_\_\_\_\_  
 Authorized Person's Signature

NOTE: A true copy of this authorization is available to the patient or his authorized representative at any time, upon request.



