

# MEDICAL LIFE INSURANCE COMPANY

ADMINISTERED BY:  
 COMBINED SERVICES, L.L.C.  
 15 NORTH MAIN STREET — Suite 300  
 CONCORD, NEW HAMPSHIRE 03301-4945  
 (603) 225-4278 (603) 224-4256 (FAX)

**PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED**

- |  |  |
|--|--|
| <input type="checkbox"/> SHORT TERM DISABILITY | <input type="checkbox"/> ACCIDENTAL DISMEMBERMENT  |
| <input type="checkbox"/> VOLUNTARY STD         | <input type="checkbox"/> SPECIFIC DISEASE BENEFIT  |
| <input type="checkbox"/> WAIVER OF PREMIUM     | <input type="checkbox"/> ACCELERATED DEATH BENEFIT |

GROUP NUMBER \_\_\_\_\_

**CLAIMANT'S STATEMENT** (Please Print)

Claimant's Name	Social Security #	Height	Weight	Birth Date
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Address Number Street City State Zip	Phone Number A/C ( )
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Employer's Name	Occupation
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Employer's Address Number Street City State Zip
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Are you filing a claim for this disability under the Workers' Compensation Act or Social Security Act?  Yes  No

Describe other income you are receiving:

yes	no	type *	amount	date benefits began	date benefits terminated
<input type="checkbox"/>	<input type="checkbox"/>	Social Security (disability or retirement)	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	State disability	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Retirement (normal, early or disability)	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Group disability benefits	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____

*\*Please send a copy of your award letter, if applicable.*

1. Date of accident or beginning of sickness: \_\_\_\_\_ Time of accident: \_\_\_\_\_

2. Nature of injury or sickness: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. If injury, describe how and where accident occurred: \_\_\_\_\_  
 \_\_\_\_\_

4. Have you ever had same or similar illness?  Yes  No If yes, give dates: From \_\_\_\_\_ To \_\_\_\_\_

5. Name of hospital(s) \_\_\_\_\_ Dates confined: From \_\_\_\_\_ To \_\_\_\_\_  
 Address of hospital(s) \_\_\_\_\_

6. Name and address of Doctor(s) \_\_\_\_\_  
 Dates of treatment: \_\_\_\_\_

7. Between what dates were you unable to perform any duties? From \_\_\_\_\_ To \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_

**Authorization to Release Information:** I hereby authorize any hospital or physician who has attended me to disclose when requested to do so by the Medical Life Insurance Company any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

**WARNING:** 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.

SIGNED: **X** ..... DATED..... 19.....  
 CLAIMANT'S SIGNATURE

**EMPLOYER'S STATEMENT (complete shaded area only if this is a claim for Waiver of Premium)**

Employee's Name		Social Security Number	Date of Hire	Effective Date of Employee's Insurance	
Last day worked full time	Date returned	Base Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Class	Hours worked per week
Workers' Comp. Claim filed for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		SELF ADMINISTERED ONLY: Amount of Weekly Disability Benefit: \$			
Amount of insurance in force: \$	Through what date were premiums paid:		Normal Retirement Age		
If this is a claim for Voluntary STD, are premiums for claimant's coverage paid on a pre-tax basis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Signature		Title	Date	Phone Number ( )	

**ATTENDING PHYSICIAN'S STATEMENT**

**(Must be completed in full at no expense to Medical Life)**

Patient's Name	Address	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age
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- Sickness
- 1. Nature and origin of  Injury **DIAGNOSIS** (Describe complications, if any.) \_\_\_\_\_
- 2. Date symptoms first appeared or date of accident: \_\_\_\_\_
- 3. When did patient first consult you for this condition? \_\_\_\_\_
- 4. Is this condition work related?  Yes  No \_\_\_\_\_
- 5. Describe any other disease or complications affecting present condition: \_\_\_\_\_
- 6. Date and nature of surgical or obstetrical procedure, if any. (Describe fully and give approach used if more than one) \_\_\_\_\_
- 7. If Maternity, give estimated date of delivery: \_\_\_\_\_  Normal  C-section
- 8. Give all dates of treatment and nature of treatment other than surgical: \_\_\_\_\_
- 9. If patient hospitalized, give name and address of hospital and dates: Hospital \_\_\_\_\_  
Address \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_
- 10. Has patient ever had same or similar condition?  Yes  No (If yes, state when and describe.) \_\_\_\_\_
- 11. Is patient still under your care for this condition?  Yes  No (If discharged, give date and degree of recovery.) \_\_\_\_\_
- 12. Is patient under the care of another physician?  Yes  No (If yes, provide name and address of physician.) \_\_\_\_\_
- 13. How long was or will patient be continuously totally disabled (unable to work)?  
In his own occupation ..... From \_\_\_\_\_ Through \_\_\_\_\_  
In any occupation ..... From \_\_\_\_\_ Through \_\_\_\_\_
- 14. Date patient can return to work ..... \_\_\_\_\_
- 15. How long was or will patient be partially disabled? ..... From \_\_\_\_\_ To \_\_\_\_\_
- 16. In your opinion, is patient a candidate for rehabilitation:  Yes  No
- 17. Does patient have a life expectancy of 12 months or less?  Yes  No

Remarks \_\_\_\_\_

Physician's Signature \_\_\_\_\_ TITLE \_\_\_\_\_

Name (Please Print) \_\_\_\_\_

Address \_\_\_\_\_  
Number Street City State Zip

Date \_\_\_\_\_ Phone Number A/C ( ) \_\_\_\_\_