

Medical Life Insurance Company
1220 Huron Road
Cleveland, Ohio 44115-1700

Group Long Term Disability Claim Form

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

NOTICE OF CLAIM — Employer's Instructions

Approximately 6 to 8 weeks before the end of the elimination period:

- A. Complete the Employer's Report of Claim in full;
- B. Give claim form to claimant for completion; and
- C. Request copy of awards from other sources of benefits: Social Security, Workers' Comp., retirement, state disability, and others.

When claimant returns the form to you:

- A. Attach:
 - Job description (detailed duties)
 - Copy of enrollment card (only for contributory coverage, if available)
 - Documentation of earnings if other than straight salary
 - If Workers' Comp. claim filed, include copy of First Report of Accident and the decision
- B. Return, together with all attachments, to Medical Life at the address shown above.

APPLICATION FOR LTD BENEFITS — Employee's Instructions

- A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Medical Life or its representative to secure additional information if necessary to make a decision on your claim.
- B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

- A. Attach:
 - A copy of your birth certificate (only if disability is indefinite and you are over age 50)
 - A copy of Social Security and other income entitlement awards; and
- B. Return to your employer.

ATTENDING PHYSICIAN'S STATEMENT (APS) — Physician's Instructions

As soon as the claimant gives you this form:

- A. Complete the APS on the back of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.
- B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of his claim for disability benefits depends on you. Thank you for your prompt response.

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.

EMPLOYEE'S CLAIM STATEMENT

TO BE COMPLETED BY EMPLOYEE

CLAIMANT	1. Full Name (Last, First, Middle Init.)				2. Social Security No.		3. Phone Number ()		
	4. Address			City		State		Zip Code	
	5. Date of Birth Mo. Day Year	6. Height ft. in.	7. Weight	8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		10. Spouse's date of birth Mo. Day Year First Name		11. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Number of children (Under age 19)			13. List names and dates of birth of unmarried children who have not finished high school.						

EMPLOYMENT	14. Employer's Name				15. Group Policy No.			
	16. Occupation (List the duties of your occupation at the time of disability)							
	17. Date of accident or date first noticed symptoms of illness: Mo. Day Year		18. I have been unable to work because of the disability since: Mo. Day Year		19. I returned to work on a part time basis on: Mo. Day Year		20. I returned to work on a full time basis on: Mo. Day Year	
21. Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			22. If "yes," explain Have you or do you intend to file a Workers' Comp. Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No					

CLAIM HISTORY	23. Describe how and where accident occurred or describe the onset and nature of your illness.							
	24. Date you were first treated for your illness or injury. Mo. Day Year		25. Treated by: Hospital: _____ Name Street Address City State Zip Code Doctor: _____ Name Street Address City State Zip Code					
	26. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete No. 27.		27. Treated by: Hospital: _____ Name Street Address City State Zip Code Doctor: _____ Name Street Address City State Zip Code					

OTHER INCOME	28. Describe other income you are receiving:							
	Yes	No	Type	amount	date began	date term.		
	<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) _____	\$ _____	_____	_____			
29. Have you applied, or do you plan to apply for benefits described above? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Type _____		Date application filed _____						
Type _____		Date application filed _____						

AUTHORIZATION: I 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 Medical Life Insurance Company, 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 Medical Life, its subsidiaries or representatives is to be used solely for the administration of claim(s) as captioned above. A photocopy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

The above statements are true and complete to the best of my knowledge and belief.

Signature of Employee

Date

ATTENDING PHYSICIANS STATEMENT

Name of patient		Date of Birth		
HISTORY	(a) When did symptoms first appear or accident happen?	(b) Date patient ceased work because of disability?	(c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes If "Yes" state when and describe <input type="checkbox"/> No	
	(d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(e) Names and addresses of other treating physicians		
DIAGNOSIS	(a) Diagnosis (Including complications)	(b) If pregnancy, est. date of delivery	(c) Subjective symptoms	
	(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings?)			
TREATMENT	(a) Date of first visit	(b) Date of last visit	(c) Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)	
	(d) Nature of treatment (Including surgery and medications prescribed, if any)			
PROGRESS	(a) Has patient <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?	(b) Is patient <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?		
	(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from _____ through _____ If, yes, give Name and Address of Hospital:			
CARDIAC	(a) Functional capacity (American Heart Ass'n.) <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation)	(b) Blood Pressure (last visit) _____ systolic/diastolic		
	(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles). <input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity* (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%) Remarks:			
IMPAIRMENT	(b) Mental Impairments (If applicable) (a) Please define "stress" as it applies to this claimant. (b) What stress and problems in interpersonal relations has claimant had on job? <input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks:			
	(a) Is patient now totally disabled? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No			
PROGNOSIS	(b) Date patient became disabled due to present illness		(c) When do you expect a fundamental or marked change in the future? <input type="checkbox"/> 1 Mo. <input type="checkbox"/> 1-3 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> Never. Applies To: <input type="checkbox"/> Patient's job <input type="checkbox"/> Other Work	
	(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Can present job be modified to allow for handling with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
REHAB	(c) When could trial employment commence? Date _____ PATIENT'S JOB <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date _____ ANY OTHER WORK <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time			
	(Limitations, Therapy, etc.)			
Name (Attending Physician) <i>Print</i>		Degree	Telephone () Fax #: ()	
Street Address		City or Town	State	Zip Code
Signature			Date	