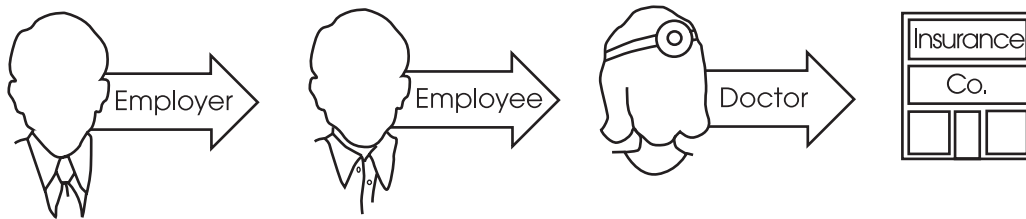


Group Division

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
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			10. Work schedule at time last worked No. of days per week _____ No. of hours per day _____
	9. Occupation at time last worked (attach job description)			
	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"/> Salary & Bonus <input type="checkbox"/> Commissions Only		14. Employee's Basic Monthly 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)
	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	
RETIREMENT	22. Is employee or will this employee be eligible for a disability or retirement pension? <input type="checkbox"/> Yes If "Yes" type: _____ Monthly Amount \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____ Commence Date of Benefits: _____ (enclose copy of summary plan description)			
	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.			
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 28. Public Employer Social Security No. 69 _____ - _____		29. Name of person completing this form (please type or print)	
	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.

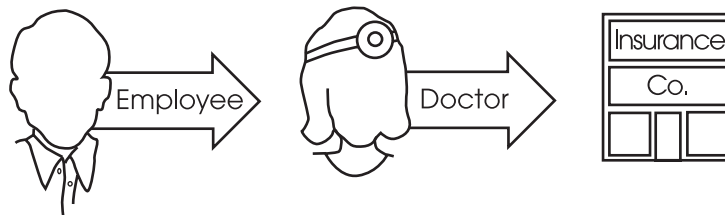


SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

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.

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.



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Group Division

Group LTD CLAIM

EMPLOYEE'S Authorization for Release of Information

Authorization - to be completed by employee

Policy No. _____

To Whom It May Concern:

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person who has attended me or has any records or knowledge of me or my health to furnish to Security Mutual Life Insurance Company of New York, or its representatives such as its attorneys, investigators or reinsurers, and any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility for benefits, and that my failure to sign this Authorization may result in denial of benefits. I understand that I may request to receive a copy of this Authorization. I agree that this Authorization shall remain valid for the duration of the claim, unless I revoke it in writing, and I understand that revocation may result in the denial of insurance benefits.

Date

Signed

