MEDICO®

LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386

Des Moines, IA 50306-0386

Toll Free 1-800-228-6080

Group Disability Claim Application

Employer:_____

Group Policy No: _____

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To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays.

The application for benefits requests information that is necessary to the speedy and accurate administration of your claim. If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (not applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization and Disclosures

You (the employee) must fully complete the "Authorization", page 2. This will allow us to secure additional information (if necessary) to make a decision on your claim.

Section 2: Employee's Statement

Fully complete the section "To Be Completed By Employee", page 3.

Section 3: Employer's Statement

Have the employer fully complete the section "To Be Completed By Employer", page 4.

Section 4: Physician's Statement

Have the attending physician complete the section "To Be Completed by Physician", page 5. Please complete the top line with your name, date of birth and social security number before giving the form to your physician.

When all sections of this form have been completed, send it to us at the above address by mail or fax.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

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AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION

Section 1: To Be Completed By Employee

To:

- Physicians and other Medical Professionals
- Consumer Reporting Agencies
- Employers
- Group Policyholders, Contract Holders/Vendors, Health Benefit Plan Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration, Veteran's Administration, Railroad Retirement Board and the Jones Act Administration)
- Hospitals and other Medical Care Institutions
- Insurers
- Prepaid Health Plans
- State Vocational Rehabilitation agencies and other providers of Rehabilitation Services
- Medical Information Bureau (MIB) or other Companies which collect health and insurance claim information

You are authorized to provide any information related to my medical condition and to job modifications/ accommodations with my current or future employer to:

- The plan administrator or claim administrator of any benefit plan under which I may be a participant,
- Medico Life and Health Insurance Company and its affiliated and associated companies, and
- Claims investigators, attorneys, and service consultants and other personnel involved in the administration, evaluation, analysis and management of the plan and/or claim (such individuals and entities are hereinafter collectively referred to as Medico Life and Health Insurance Company.

This includes, but is not limited to, any:

- Records, test results, data, and information concerning medical care, history, diagnosis, prognosis, treatment, and supplies
- Employment related information
- Income related information
- Information from credit reporting bureaus or other consumer reporting agencies
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I understand that the Information will be used for the purpose of evaluating, analyzing, managing and/or administering my claim for short term disability benefits, long term disability benefits, salary continuation, workers' compensation and/or any other health benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), for assessing and developing a vocational rehabilitation plan, and for other business purposes in connection with the administration of the Benefits Program.

I further authorize Medico Health and Life Insurance Company to re-disclose any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any benefit plan under which I may be a participant, claims investigators, attorneys, service consultants and any other entities, including the claimant's treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. Medico Health and Life Insurance Company shall require such individuals to adhere to requirements and guidelines intended to protect and preserve the confidential nature of the Information.

I understand that this authorization shall remain in force for the duration of my claim for benefits under the Benefits Program or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization and to inspect and copy any written information disclosed. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed. I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of my initial authorization, may impair the ability of Medico Health and Life Insurance Company to process my claim and may be a basis for denying or terminating my claim for benefits.

Claimant's Signature: _____ Claimant's Date of Birth: _____

Claimant's Full Name: _____ Employer: _____

Claimant's Address: _____ Date: _____

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EMPLOYEE'S STATEMENT

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1 Employee Name			**2** Social Security No.
Street/Box/Apt.			**3** Phone No. ( )
City, State, Zip			**4** Date of Birth
5 Height	**6** Weight	**7** ☐ Male ☐ Female	**8** Employer Name
9 Occupation	**10** List Occupation Duties		

11 Date of accident or date of first symptoms	**12** Last Day Worked	**13** Are you unable to work due to? (check one) ☐ Injury ☐ Illness ☐ Pregnancy

14 Date you Returned to Work	☐ Full Time	☐ Part Time
15 If you have not returned to work, when do you expect to return?	☐ Full Time	☐ Part Time

16 Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms

17 Is your accident or illness related to your occupation? ☐ Yes ☐ No
If yes, explain:

18 Have you filed a Workers' Compensation Claim? ☐ Yes ☐ No If no, do you intend to? ☐ Yes ☐ No
If no, explain:

19 When were you first treated for your illness or accident?

Hospital	Address	Date(s)
Doctor	Address	Date(s)

20 Have you ever had same or similar condition in the past? ☐ Yes ☐ No If yes, list name and address of Hospital/Doctor

Hospital	Address	Date(s)
Doctor	Address	Date(s)

21 Are you receiving? (check those benefits you are receiving)

☐ Workers' Compensation	Amount $_____ Begin_____End_____	☐ Unemployment	Amount $_____ Begin_____ End_____
☐ Social Security	Amount $_____ Begin_____End_____	☐ Other (Indiv. or Group)*	Amount $_____ Begin_____ End_____
☐ State Disability	Amount $_____ Begin_____End_____	☐ Auto Ins. Wage Replacement*	Amount $_____ Begin_____ End_____

*If yes, give name and address of Insurer

Insurer Name(s)	Address

22 ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**23** If married, spouse's name and Social Security Number	**24** Spouse Date of Birth

25 Is Spouse Employed? ☐ Yes ☐ No	**26** List Children under age 25 (Names and Dates of Birth)

27 If benefits are approved, do you want the minimum $20.00 per week withheld from your check for Federal Income Tax Purposes? ☐ Yes ☐ No
If you want more withheld, please state dollar amount you want withheld $_____

The above statements are true and complete to the best of my knowledge and belief. Your signature is required for benefit consideration.

Signature **X**_____ Date _____

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EMPLOYER'S STATEMENT

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1 Employee's Name			**2** Social Security No.
Street/Box/Apt.			**3** Date of Birth
City State, Zip			**4** Regularly Scheduled Hours Per Week
5 Date of Hire	**6** Employee's STD Effective Date	**7** Employee's LTD Effective Date	**8** Occupation
9 Policy No.	**10** Policy Division No.	**11** Policy Class	

12 Employee's Work Schedule ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal

13 Check Regular Workdays ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

14 If not at work when Disability began, (check status and provide date)
☐ Terminated ☐ Leave of Absence ☐ Other (Specify)_____
☐ Laid Off ☐ Sick Leave ☐ Date_____
☐ Vacation ☐ Resigned

15 How was employee paid? (check appropriate box)
☐ Hourly ☐ Monthly ☐ Salary and Bonus
☐ Weekly ☐ Commissions ☐ Commissions Only
☐ Biweekly ☐ Salaried ☐ Salary and Commissions

16 Salary Prior to Date Last Worked	**17** Date Last Salary Increase	**19** Comments:
Base Weekly Wages $_____	**18** Employee Work Schedule at Time Last Worked	
W-2 Earnings $_____	_____ Days Per Week	
Overtime $_____	_____ Hours Per Week	
Commissions $_____		
Bonus $_____		

20 Date Last Worked	**21** Hours Worked That Day	**22** Has Employee Returned to Work? If yes, Date_____ ☐ Yes ☐ No ☐ Full Time ☐ Part Time

23 Date Paid Through_____ For ☐ Salary Continuation ☐ Vacation ☐ Accrued Sick Pay

24 Does employee contribute toward the STD premium? ☐ Yes ☐ No If yes, ☐ Pre-Tax ☐ Post-Tax
If Post-Tax _____% paid by employer _____% paid by employee

25 Does employee contribute toward the LTD premium? ☐ Yes ☐ No If yes, ☐ Pre-Tax ☐ Post-Tax
If Post-Tax _____% paid by employer _____% paid by employee

26 Employee is Eligible for	Yes	No	If yes, Weekly or Monthly Amount	Wk.	Mo.	Provider Name/Address	Date Benefits Begin	Through
Salary Continuation	☐	☐	$	☐	☐			
Disability Pension	☐	☐	$	☐	☐			
Retirement Pension	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Unemployment	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Workers' Compensation	☐	☐	$	☐	☐			
Has Workers' Comp. claim been filed?	☐	☐	If Workers; Compensation has been denied, submit copy of denial with this claim.					

27 Does your company have a rehire or return to work policy for disabled employees? ☐ Yes ☐ No
What is the name of the person we should contact if we identify a return to work option?

28 Name/Address of the employee's medical insurance carrier or HMO (provide policy or ID No.)

29 Employer's Name			Phone No. ( )
Address Street	City	State	Zip
Signature (The above statements are true and complete to the best of my knowledge) **X**		Date	

A Job Description is required if employee is out of work more than 6 weeks.

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PHYSICIAN'S STATEMENT

Section 4: To Be Completed By Physician

Patient Name	Date of Birth	Social Security No.

How long was/will patient be unable to work? From _____ Through _____

1 Patient is/was unable to work due to: (check one) ☐ Injury ☐ Illness ☐ Pregnancy

2 Diagnosis (include complications and ICD code) | If Pregnancy, estimated delivery date

3 When did symptoms first appear or accident happen? | **4** Date you advised patient to stop working | **5** Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No

6 Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe

7 Date of First Visit | **8** Date Last Visit | **9** Frequency of Visits

10 Objective Findings (X-rays, EKGs, lab data and clinical findings) | **11** Subjective Symptoms

12 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency

13 Names and addresses of other physicians

14 Has patient been hospitalized? If yes, give name and address
☐ Yes ☐ No From _____ To _____

15 Restrictions (what the patient SHOULD NOT do) | **16** Limitations (what the patient CAN NOT do)

17 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis
I
II
III
IV
V

18 If this is a cardiac condition, what is the functional capacity? (American Heart Association)
☐ Class 1 - No Limitation ☐ Class 2 - Slight Limitation ☐ Class 3 - Marked Limitation ☐ Class 4 - Complete Limitation

19 Has maximum medical improvement been achieved? ☐ Yes ☐ No If no, when do you expect a fundamental change?
☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ more than 6 weeks

20 If employer can accommodate patient's limitations and restrictions, is patient able to return to work? ☐ Yes ☐ No
What date could employment begin _____

21 Physician Name (Please Print)			Degree
Specialty	Phone No.	Fax No.	
Address	City	State	Zip
Signature (No Stamp) **X**	Tax ID No.		Date