Long Term Disability Claim Statement—Conversion



For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the state of Alaska, the following statement applies to you:

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

If you live in the state of Alabama, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

If you live in the states of Arkansas, Louisiana, Massachusetts, Minnesota, New Mexico, Rhode Island, Texas or West Virginia, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of Arizona, the following statement applies to you:

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the state of California, the following statement applies to you:

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in the state of Colorado, the following statement applies to you:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you live in the District of Columbia, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the states of Delaware, Idaho or Indiana, the following statement applies to you:

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

If you live in the state of Florida, the following statement applies to you:

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Sun Life Financial is the brand name for products underwritten or provided by Union Security Insurance Company.

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Following is the information for claim submission:

If you live in the state of Kansas, the following statement applies to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

If you live in the state of Kentucky, the following statement applies to you:

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.

If you live in the state of Maryland, the following statement applies to you:

Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of Maine, the following statement applies to you:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

If you live in the state of New Hampshire, the following statement applies to you:

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.

If you live in the state of New Jersey, the following statement applies to you:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

If you live in the state of Ohio, the following statement applies to you:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud

If you live in the state of Oklahoma, the following statement applies to you:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

If you live in the states of Oregon or Virginia, the following statement applies to you:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

If you live in the states of Tennessee or Washington, the following statement applies to you:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

If you live in the state of Vermont, the following statement applies to you:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

If you live in a state other than mentioned above, the following statement applies to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Long Term Disability Claim Statement—Conversion



INSURED'S IDENTIFYING INFORMATION		□New claim		☐Claim already submitted	
Full name of insured (<i>Please print</i> .)		2. Certificate number		3. Date of birth	
4. Full address		5. Phone number		6. Social Security number	
		7. □Male □Female		8. Marital status ☐Single ☐Married	□Widowed
EMPLOYMENT INFORMATION			-		
Name and address of employer from the second s	om whose policy you conver	ted		10. Occupation	
11. Are you currently employed?	12. Current occupation		13. Number	er of hours worked per week	
14. Name and address of current employer				15. Phone numbe	er
DISABILITY INFORMATION					
17. Date of first medical treatment for	this condition	18. Date on whi	ch you were fil	rst unable to work	
If pregnancy, indicate conception a	and/or delivery date.				
19. Have you engaged in any work, pa (If "Yes," please explain and give of		your sickness or inju	ury began?	□Yes □No	
20. If you have recovered or returned	to work, give date.	21. If still totally	disabled, when	n do you expect to	return to work?
22. Names and addresses of all physi Name	cians who have been consu Address	Ited because of this		f Consultation or T	Freatment
23. Have you been confined to a hosp	ital for this disability?	Yes □No (If "Y	es," please co	umnlete \	
Name of Hospital	Address	ies Livo (ii i			through

OTHER BENEFITS							
24. Are you receiving, or are you entitled to receive, benefit	its from	n any of	the follo	owing sources? I	Each question must l	be answere	d.
A. Salary, wages or commissions?	Yes	No	F. Wo	rkers' Compensa	tion or similar legislation		No
B. Retirement or pension plan?				-	ailroad Retirement Act		
						: ⊔	
C. Veterans Administration				er governmental	rovincial, municipal or agency?		
D. Any group insurance, health or welfare plan?			H. No-	Fault or other au	tomobile insurance?		
			I. Othe	er sources? (Give	e details below.)		
For each question answered "Yes," please furnish the f	followin	ng inforn	nation:				
Name and Address Group or Policy or Claim of source Individual Basis Number (if any)	Comr	Date Beneded	or Will	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amou Benefits P	
For Social Security, Workers' Compensation, and other sin applicable).	imilar b	enefits,	please	furnish a copy o	f the benefit award (or	denial letter	; if
AUTHORIZATION I authorize any provider of medical services, insurance governmental agency, educational institute, law enforany physical or mental condition, rehabilitation and of Company, or its representative, any and all such informy limitations/restrictions with treating physicians at and possible return to work. I UNDERSTAND the ir Security Insurance Company to determine the eligible shall be as valid as the original. I agree this Authority and governed by HIPAA, however, when necessary, Security Insurance Company to use and disclose profit I receive a disability benefit greater than that which right to recover such overpayments from me, including	orcement other normation of cur or normal bility for ization I may rotecte	ent agen non-me on. I unor rent or ation ob or bene n shall I be ask ed healt	ncy, or dical ir dersta prosp btained efits. I be vali ked to th infor	employer having formation of mand Union Secuective employed by use of this know that a phad for the durative execute a HIPA mation.	ng medical information of the to give to Union Serity Insurance Compress as they relate to a Authorization will be otographic copy of the claim. This A authorization form	on with respecurity Insurany may diaccommodae used by his authorization, allowing company ha	pect to grance scuss ations Unior zatior tion is Unior
Signature of claimant					Date		

HIPAA Authorization For Release of Protected Health Information



Insured/Member name_		SSN	DOB	
Address	с	ity	State	Zip
Policy no.	Participation no	Account no	Certificate	no
medical or medically rela cy-related services entity	persons <u>providing</u> the info ated facility; insurance or rein y; federal, state or local gove tional institute; vocational pro	nsuring company; pharmac rnment agency including th	ist, pharmacy benefits ne Social Security Adn	manager, or pharma-
	persons <u>receiving</u> the infolence York ("Companies").	rmation: Union Security In	surance Company or	Union Security Life
I hereby authorize the us	se or disclosure of my inform	ation as described below:		
tatives to determine my records about my physic AIDS or other immune d garding Social Security I and pension benefits; ea	losed: All medical and non-meligibility for benefits and to peal and mental health, includitisorders, sexually transmitted benefits, Worker's Compensationings records; tax records a	orocess my claim. Such info ng diagnosis or treatment f d diseases, use of alcohol ation and other insurance o	ormation may include, for Human Immunode and/or drugs; pharma claims and benefits, St	but is not limited to: ficiency Virus (HIV), cy records; records re- tate Disability benefits,
I understand the following	ng:			
my current disa information to rations and possi vocational, or or adjudication of Social Security adjudicate other I have the right the Companies benefits under exation is as valional to the second of the receipt of	quires that we inform you that us to third parties and thus r at any information obtained b	isclosed to the Companies rent or prospective employ nation may also be release employed by or representing a Social Security vendor insurance companies or the me. I refuse the information necessary to ance policies. I understand the standard revocation will not affect the information that we conclude the information that we co	reinsurer(s). The Corrers relating to restriction to (a) any medical, ing the Companies with that may assist me in their representatives to to sign this authorization determine if I am eligithat a photocopy or fathis authorization. In Life Financial, Privated any actions that Collect may, under certain law.	mpanies may release ons, accommoda- nvestigative, financial, in the evaluation and filing a claim with the help investigate and ion, I understand that gible for coverage or acsimile of this authorities. PO Box companies took before in circumstances, be
This authorization is effe	ective from the date signed be	elow for 24 months.		
SIGNATU	RE OF INSURED/MEMBER OR LEGAL	PERSONAL REPRESENTATIVE		DATE
PRINTE	ED NAME OF LEGAL PERSONAL REPR	ESENTATIVE	RELATIONSHIP	TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Sun Life Financial is the brand name for insurance products underwritten by Union Security Insurance Company.

Attending Physician's Initial Statement of Disability



The patient must pay any costs for completion of this form.

To the Attending Physician

Do not separate the pages of this claim statement.

Please read the following instructions before completing this form.

An authorization to release information can be found on pages 4 and 5.

Clearly print or type this form. Fully complete each applicable section of this form.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient		Date of birth	Social Security number				
	D						
History	Patient's symptoms result from (Check all that apply.):	□Employment □IIIn					
		☐Motor Vehicle Acciden	t □Pregnancy				
	If pregnancy, (expected/actual delivery date)	Type of delivery					
	Date symptoms first appeared	Patient's height_	Weight				
	Name(s), address(es), specialty(ies) of other treating or referring physician(s)						
	First visit for this conditionMost recent	visitMost rece	ent comprehensive exam				
	Hospital namethru						
	Diagnoses with ICD9-CM codes: list in descending orde	r of severity (including any con	inplications). Please go to the appropriate				
	assessment section and elaborate. ICD9						
	Subjective symptoms						
es							
nos	Objective findings						
Diagnoses	objective initiality						
	Attach medical records which document the above and scans)	diagnostics. (Include results/o	copies of x-rays, lab tests, EKGs, MRIs				
	Do you believe a legal guardian or conservator should be appointed for this patient? ☐Yes ☐No						
	In terms of an 8 hour day:						
	□Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently.						
	Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently.						
	□Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently. □Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting.						
	□Class 5—Severe limitation; incapable of minimal activ		Bed confined House confined				
al snt	Coldes of Covere infinitation, incapable of minimal deliv	•	t of Labor's Federal Dictionary of Occupational Titles				
ion	Please fully describe the patient's capabilities: *With all						
Functional Assessment	N =Never O =Occasionally (1/4–2 1/2 hours) F =Frequ	ently (2 1/2–5 1/2 hours) C =C	ontinuously (5 1/2–8 hours)				
F _L	Standing* Sitting* Walking	y* Driving*	Bending* Data Entry*				
	Lifting not more than pounds(how o	often) Carry not more than _	pounds (how often)				
	When did these capabilities begin?						
	Do you anticipate an increase in your patient's functional	al capabilities?	late				

Treatment	Describe treatment program and give dates of any surgery, medications (dosages/administration routine), physical therapy or psychotherapy.						
Treat	Frequency of treatment and/or symptoms: Weekly Monthly Other (Specify.)						
	Next scheduled visit						
Cardiac	Complete only if applicable. Functional capacity (American Heart Association) Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation) Blood pressure (latest reading) as of (date) METS level Date Ejection fraction % Date Is patient in a cardiac rehabilitation program? Yes No If "Yes," please include dates. Start End End						
	List the patient's DSM Code(s):						
	Description	_					
		_					
	Please define stress as it applies to this patient.						
Psychiatric Assessment	What stress and problems in interpersonal relations has patient had on the job?						
Ps) Ass	Please fully describe the patient's limitations.						
	When did these limitations apply?						
	BeganAnticipated reductionAnticipated end date						
	Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No	_					
	Is patient a candidate for vocational rehabilitation services? Yes (Describe.) No (Explain.)						
Rehab	Describe any job modifications that would aid your patient in performing his/her work tasks.						
	Has patient reached maximum medical improvement?						
	Physician's nameDegreeSpecialty/Board certification						
ē	Address						
Name	STREET CITY STATE ZIP CODE Telephone noFax no						
	SignatureDateDO NOT PRE-DATE	_					