Manhattan Life Insurance Company
Family Life Insurance Company
Western United Life Assurance Company
ManhattanLife Assurance Company of America

Worksite Benefits
Claims Department
P.O. Box 925309
Houston, Texas 77092-5309

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: _____ Policy No: _____
I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative
(e.g., parent or guardian, if minor)

Authorization for Policyholder Initiated Request for Release of Protected Health Information to Other

ManhattanLife Since 1850

Name or Employer	Policy Number

Primary Policyholder Covered by the Health Plan (Last, First)

Name of Person Granting Authorization (Last, First) Leave blank if same as Primary Member	Relationship to Primary Policyholder (self, spouse, dependent child or designated personal rep)

My protected health information is information about me that was collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; Iii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

For my purposes and at my request, I authorize Manhattan Life Insurance Company, Family Life Insurance Company, Western United Life Assurance Company and ManhattanLife Assurance Company of America to disclose my protected health information to the following Individual, organization, or class of persons (e.g., group Individuals within the organization) (check all that apply):

- ❑ My Spouse: (specify)
  The protected health information that may be used and disclosed to my Spouse is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status or Protected Health Information related to Claims Status
  - ❑ Other (specify) _____
- ❑ My Employer/ Plan Sponsor:
  The protected health information that may be used and disclosed to my Employer/Plan Sponsor is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status
  - ❑ Other (specify) _____
- ❑ Agent: (specify)
  The protected health information that may be used and disclosed to my Broker is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status
  - ❑ Other (specify) _____
- ❑ Other: (specify) _____
  The protected health information that may be used and disclosed to this specified Individual(s) is as follows (check all that apply):
  - ❑ Eligibility
  - ❑ Explanation of Benefits
  - ❑ Claims Status
  - ❑ Other (specify) _____

[If choosing "Other", describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

I understand that I may refuse to sign this authorization. I further understand that the above named health plan will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the above named health plan at the address located below, and this revocation will be affective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that the above named health plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the above named health plan and, by law, the above named health plan has a right to contest the coverage.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires at the earlier of: 1) 12 months from the date when it was signed or 2) when I am no longer an active policyholder of the above named health plan.

_____
Signature of Person Granting Authorization or Personal Representative

_____
Date

Printed Name_____
(Last) (First)

_____
Description of Personal Representative's Authority (if applicable)

You may contact me at the address below if you have questions concerning my responses in the Authorization

_____
Street Address City State

Phone: (_____) _____

Email: _____

Send your completed authorization or notice of revocation to the following address:
Claims Department
P.O. Box 925309, Houston, Texas 77092-5309
or
FAX to (713) 583-8508

NOTE: All authorizations granted by this document are in addition to any uses and disclosures of protected health information permitted or required under the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations.

This form is not to be used for obtaining records from providers for underwriting or risk rating.

INDIVIDUAL DISABILITY CLAIM FORM

Name of Insured	Policy Number	Date of Birth	Home Telephone

Home Address (Street, City, State, Zip) ❑ Please Check if this is a change of address

Name of Employer	Business Telephone	Social Security Number

Business Address	Monthly Gross Earned Income $

Please check any and all benefits that you are eligible to receive:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Policy No.	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
A. Social Security	❑	❑	❑	❑					
B. State Disability Insurance	❑	❑	❑	❑					
C. Retirement or Pension	❑	❑	❑	❑					
D. Short Term Disability	❑	❑	❑	❑					
E. Salary Continuation	❑	❑	❑	❑					
F. Unemployment	❑	❑	❑	❑					
G. Worker's Compensation	❑	❑	❑	❑					

DATE of your accident or the date you first noticed the symptoms of your illness:	Date you last worked:	I returned to work on a part-time basis on:	I returned to work on a full time basis on:
Month Day Year	Month Day Year	Month Day Year Have not returned yet ❑	Month Day Year Have not returned yet ❑

Describe your disability and its cause. If accidental, please provide **COMPLETE** accident details including **WHEN, WHERE** and **HOW** the accident occurred. If you were in an automobile accident, please provide a copy of the police report.

Are you covered by Workers Compensation for this disability? ❑Yes ❑No

List all physicians or other practitioners consulted for this condition. (Use additional pages if needed.)

Name	Address	Dates Consulted

List **ALL** physicians or practitioners consulted **FOR ALL CONDITIONS** in the past five (5) years. (Use additional pages if needed.)

Name	Address	Dates Consulted/Reason for Consultation

List **ALL** hospital confinements **FOR ALL CONDITIONS** in the past five (5) years. (Use additional pages if needed.)

Name	Address	From	To	Reason Confined

The Statements in this form are true and complete to the best of my knowledge.

Signature (Insured) Date

YOU MUST ANSWER ALL QUESTIONS IN THEIR ENTIRETY.
INCOMPLETE FORMS WILL BE RETURNED AND WILL DELAY PROCESSING OF YOUR CLAIM.

Submit Completed Form to: Claims Department, P.O. Box 924408, Houston, TX 77292-4408
Customer Service Department (800) 999-2971 or (713) 821-6566
www.manhattanlife.com

ManhattanLife Since 1850

OCCUPATIONAL INFORMATION

TO BE COMPLETED BY THE INSURED

What was your occupation immediately prior to the date you became disabled?

List all duties of the occupation noted above. (Failure to be specific may result in a delay in the processing of your claim.)

Description of Each Duty	Weekly % of Time Devoted to this Activity	Weekly Hours Spent at this Activity

Describe briefly which of these duties you are unable to perform as a result of your sickness or accident, and why.

Describe briefly your prior work experience and education.

TO BE COMPLETED BY THE EMPLOYER (if retired, by the former employer)

Employer Name	Employer's Telephone Number
Employer Address (street, city, state, ZIP code)	
Worker's Compensation Claim Filed? ❑ Yes ❑ No	Name of Compensation Carrier
Address, and Telephone Number of Compensation Carrier	
Between what dates did employee give up all duties due to TOTAL DISABILITY? From: To:	
Name of Previous Disability Insurer:	
Effective Date:	Term Date:
Date Title	Signature

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY; FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION; IS GUILTY OF A FELONY OF THIRD DEGREE.

The Statements in this form are true and complete to the best of my knowledge.

_____ _____

Signature (Insured) Date

ALL QUESTIONS MUST BE ANSWERED IN THEIR ENTIRETY.
INCOMPLETE FORMS WILL BE RETURNED AND WILL DELAY PROCESSING OF YOUR CLAIM.

Submit Completed Form to: Claims Department, P.O. Box 924408, Houston, TX 77292-4408
Customer Service Department (800) 999-2971 or (713) 821-6566
www.manhattanlife.com

ManhattanLife Since 1850

ATTENDING PHYSICIAN'S INITIAL REPORT

Please print all entries. This form is to be completed without expense to the company.

Name of Patient (last, first, middle initial)	Was patient referred by another physician? ❒Yes ❒No Name & Address:	
DIAGNOSIS: (If psychiatric in origin, please indicate DSM III code and axis.)		
What limitations are there on your patient's ability to perform his or her job duties?	Date Restrictions Began (Mo. Day Year)	
When do you expect that these limitations/restrictions will allow your patient to return to work?		
When were you first consulted for this condition? (Mo. Day Year)	How did this condition develop? (Causes leading to Disability)	
Any previous occurrences of this condition or similar conditions? If so, please provide dates and details:		
Dates of all other visits to your office:	Is patient currently being treated by any other practitioner or therapist? ❑Yes ❑No Name & Address:	
How long was or will patient be **CONTINUOUSLY TOTALLY DISABLED**? **EXACT Start Date:** _____ **TO:**_____	How long was or will patient be **PARTIALLY DISABLED**? **EXACT Start Date:** _____ **TO:** _____	If this is a **PREGNANCY**, provide the inception date and the date of delivery or the estimated due date: **INCEPTION DATE:**_____ **DUE DATE**:_____ **DELIVERY DATE:**_____
Name and address of hospitals and dates of confinement:		
Describe past treatment for this condition, including any surgical procedures:		
Describe course of treatment to be followed; including surgery:	Is patient still under your care? ❑Yes ❑No If "No," please explain	
Please list other disability insurers to whom you are providing information on this patient.		
Does your patient have any chronic or recurring condition(s) not noted above? ❑Yes ❑No Please provide details:		
Remarks or Additional Comments:		
Name of Attending Physician (please print)	Degree Code	Telephone Number
Address (Street or P.O. Box, City, State, Zip)		Tax Payer I.D. Number
Signature of Physician		Date

ALL QUESTIONS MUST BE ANSWERED IN THEIR ENTIRETY BY YOUR PHYSICIAN.
INCOMPLETE FORMS WILL BE RETURNED AND WILL DELAY PROCESSING OF YOUR CLAIM.

Submit Completed Form to: Claims Department, P.O. Box 924408, Houston, TX 77292-4408
Customer Service Department (800) 999-2971 or (713) 821-6566
www.manhattanlife.com

ManhattanLife Since 1850

Claim Form Addendum: Fraud Warning and State Versions

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

Alabama 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. **Alaska** 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. **Arkansas** 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. **Arizona** 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. **California** For your protection California law requires the following to appear on this form. Any person who knowingly presents 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. **Colorado** 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. **Delaware** 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. **District of Columbia** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Florida** 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. **Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **Kentucky** 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. **Louisiana** 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. **Maine** 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. **Maryland** 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. **Minnesota** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **New Hampshire** 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. **New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New Mexico** 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 civil fines and criminal penalties. **New York** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **Ohio** 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. **Oklahoma** 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. **Pennsylvania** 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. **Puerto Rico** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. **Rhode Island** 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. **Tennessee** 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. **Texas** 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. **Virginia** 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. **Washington** 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. **West Virginia** 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.