Disability Continuation Claim

Please check the box next to your insurance company's name.
❑ Central United Life ❑ Manhattan Life ❑ Family Life ❑ UniLife ❑ Unum
❑ American States ❑ American General ❑ Loyal American ❑ Gold Cross

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 the third degree.

Please complete the following form and have your attending physician complete the reverse side in approximately 30 days or sooner if your disability terminates.

Your Name _____ SSN _____ Policy Number _____

Have you attempted any employment since you became disabled? ❑ Yes ❑ No

If yes, Name of Employer: _____ From _____ To _____

Address: _____

If PRESENTLY employed, on what date did you resume work? _____

What are your duties? _____

If you are working part time, how many hours _____ a day and days _____ a week?

Do you believe your health is improving? ❑ Yes ❑ No

In your opinion, are you able to do some kind of work? ❑ Yes ❑ No

When do you think you might be able to return to work? _____

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	❑	❑	❑	❑					

I hereby authorize all medical sources' designated, medical custodians, or database custodians to use and/or disclose my protected health information (PHI), as described in more detail below, to Central United Insurance Company or its affiliate indicated in the header of this page. I specifically authorize the use and disclosure of the following PHI: Photocopies of or information regarding any and all medical records, including lab and radiology results and any and all records kept separately, for the period specified on the attached request, or _____. This PHI is being used for Central United Life to process and determine eligibility for claims. This authorization shall be in force and effect until the claim is finalized or _____ at which time this authorization to use or disclose this PHI expires. I understand and agree that: I have the right to revoke this authorization, in writing, at any time by sending such written notice to the company. A revocation is not effective except to the extent that the company has relied on the use or disclosure of the PHI; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law; the company will not condition my treatment, payment, and enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure; and that I have the right to refuse to sign this authorization form.

_____ _____
Signature of Claimant Date

_____ _____ _____
Address (❑ Please check if this is a change of address) State Zip Code Telephone Number

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

DCC 1213 (rev. 3.12.15)

MANHATTAN INSURANCE GROUP

Attending Physician's Statement – Disability Continuation Claim

To be furnished without expense to the Company

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 the third degree.

Patient's name	Patient's Date of Birth

1. Nature of sickness or injury. (Describe complications, if any) If this is a pregnancy, provide the date of delivery or estimated due date.

2. Describe any other disease or infirmity affecting present condition.

3. Give date of treatments.
(Since _____) Office: _____
Home: _____
Hospital:

4. Is patient still under your care for this condition? ❒ Yes ❒ No
If discharged, give date:

5. How long was or will patient be continuously totally disabled (unable to work?)
From: Through:

6. How long was or will patient be partially disabled?
From: Through:

7. Was patient confined to the house? Yes ❑ No ❑
(If "Yes", give dates) From: Through:

PHYSICIAN'S REMARKS

FAILURE TO PROVIDE ALL INFORMATION BELOW MAY DELAY CLAIM PAYMENT

Date | Signature of Attending Physician | M. D. (Degree)

Street Address | City or Town | State | ZIP Code

( ) Telephone Number

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

MANHATTAN INSURANCE GROUP

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; lii) 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.