VB Continuing Disability Claim Form
Employee Statement

Employee's Name_____ Policy No._____
(If this is a name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.)

Date of Birth_____ Mailing Address_____

City_____State_____ZIP Code_____

Phone No._____

Since your disability began, have you been able to perform any work? ☐ Yes ☐ No

If yes, complete the following:

Employer_____Occupation_____

Dates worked_____

Have you returned to work ☐ Yes ☐ No If yes, date returned _____

If no, what is your anticipated return to work date_____

What aspect of your condition is preventing you from returning to work:

_____

_____

Are you employed with any other employer other than the one listed above? ☐ Yes ☐ No

Employer_____ Occupation_____

Dates worked_____ Phone No. _____

Name of Treating Physician_____

Phone No. of Treating Physician_____

Deduction of Premiums

To keep your policy active premiums can be deducted from your disability benefit payments. By deducting premiums this will ensure the policy stays current and eliminates the risk of your policy terminating for non-payment of premiums. To prevent claim delays, check the appropriate option below.

☐ No, I do not want my premiums deducted from my disability benefit

☐ Yes, I do want my premiums deducted from my disability benefit

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See state specific fraud warning statements on page 3).

The above Statements are true to the best of my knowledge and belief.

_____ _____ _____
Signature Printed Name Date

Direct Deposit Authorization

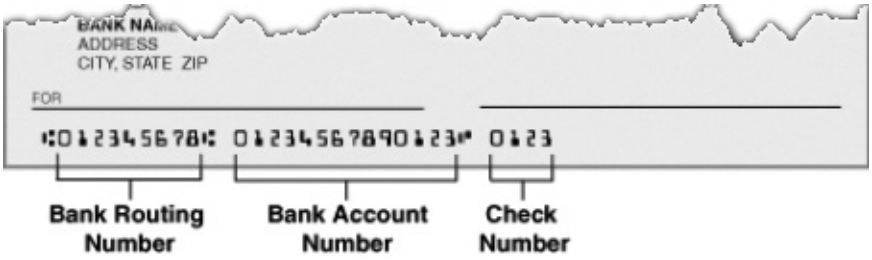
ManhattanLife™

Check Action			Account Type		Ownership of Account	
☐	☐	☐	☐	☐	☐	☐
New	Change	Cancel	Checking	Savings	Self	Other

Bank Name_____

Bank Routing Number_____ Bank Account Number_____

Policy Holder's Name _____ Policy Number _____



Terms and Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program, please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by ManhattanLife, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be canceled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife or cannot be made to your account, will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be canceled by your financial institution or ManhattanLife. **Your participation will be canceled automatically if you terminate participation in the above Account(s).**

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ _____ _____

Signature Printed Name Date

VB Continuing Disability Claim Form
Physician Statement

Disability Information:

Patient Name_____Date of Birth _____Height_____Weight _____

Treatment Information:

Current Diagnosis (Including any complications)_____

Diagnosis Code(s) (ICD-9; ICD-10)_____If mental health diagnosis, complete the DSM- IV -TR axis diagnosis section below:

Axis I _____Axis II_____ Axis III_____ Axis IV_____ Axis V_____ GAF or the DSM-V; WHODAS 2.0 Score_____

Date Assessed_____

Date of Last Visit_____**(Please submit medical records from this visit)**

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other(Specify)_____

Objective Findings (including current x-rays, EKG, laboratory data and any clinical findings)

Patient's progress: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

Patient is currently: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Patient's **current treatment plan** for this condition (including any rehab programs)_____

_____

_____

List any **current Medications** (include date of change if applicable) _____

_____

Have any subsequent surgeries been performed? ☐ Yes ☐ No If "Yes", surgery date_____

Code(s)/procedure performed_____

Has patient been hospital confined? ☐ Yes ☐ No

If"Yes", Admit Date_____Discharge Date_____

_____ _____

Hospital Name Address

VB Continuing Disability Claim Form
Physician Statement

Patient Name_____ **Date of Birth**_____

Impairment:

Cardiac Functional Capacity Limitations (American Heart Association – if applicable):

☐ Class 1 (None) ☐ Class 2 (Slight) ☐ Class 3 (Marked) ☐ Class 4 (Complete)

Blood Pressure(Last Visit) _____ Comments _____

Physical Impairments (As defined in Federal Dictionary of Occupational Titles):

☐ Class 1 - No limitation of functional capacity capable of heavy work. No restriction (0% - 10%)
☐ Class 2 - Medium manual activity (15%-30%)
☐ Class 3 - Slight limitation of functional capacity, capable of light work (35%-55%)
☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative sedentary activity (60%- 70%)
☐ Class 5 - Severe limitation of functional capacity, capable of minimum sedentary activity (75%-100%)

Comments: _____

Mental Impairments:

☐ Class 1- Patient is able to function under stress and engage in interpersonal relations. (No limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in interpersonal relations. (Slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in limited interpersonal relations. (Moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment. (Severe limitations)

Comments: _____

Functional Ability:

Estimate your patient's ability to perform the following tasks based on your knowledge of the patient

Activity:	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Number of Hours (less than 25%, 50%, 75%, 100%)
Standing	☐	☐	☐	☐	_____
Walking	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	_____
Kneeling	☐	☐	☐	☐	_____
Twisting/bending/stooping	☐	☐	☐	☐	_____
Reaching above shoulder level	☐	☐	☐	☐	_____
Operating heavy machinery	☐	☐	☐	☐	_____
Keyboard use/repetitive hand motion	☐	☐	☐	☐	_____

	Lifting/Carrying				**Pushing/Pulling**			
	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)
Up to 10lbs	☐	☐	☐	☐	☐	☐	☐	☐
11 to 20lbs	☐	☐	☐	☐	☐	☐	☐	☐
21 to 50lbs	☐	☐	☐	☐	☐	☐	☐	☐
51 to 100lbs	☐	☐	☐	☐	☐	☐	☐	☐

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Physician Statement

Patient Name_____ Date of Birth_____

Prognosis and Restrictions:
Is the patient currently disabled from their job? ☐ Yes ☐ No From any other work? ☐ Yes ☐ No

When do you expect a fundamental or marked change in the patient's condition?
☐ Less than 1 month ☐ 1 Month ☐ 2-3 Months ☐ 4-6 Months ☐ Other

What date can employment resume?_____ ☐ Full-time ☐ Part-time

What date can employment resume in another occupation?_____ ☐ Full-time ☐ Part-time

If the return to work date is unknown currently, please indicate date of next appointment:_____

Describe **fully** how the patient's conditions/limitations are affecting their ability to work, including any physical restrictions:

_____

_____

_____

_____

_____

If terminal, what is the life expectancy:
☐ 6 months or less ☐ 9 months or less ☐ 12 months or less ☐ Greater than 12 months

Additional Comments:

_____

_____

_____

_____

_____

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 6)

The above statements are true to the best of my knowledge and belief.

Printed Name of Physician_____ Phone No._____
Specialty_____ Tax ID_____
Street Address_____ City_____
State_____ ZIP Code_____ Fax No._____
Email Address_____

_____ _____
Signature of Physician Date

*Note form must be signed by medical doctor duly licensed in the state where services are rendered

ManhattanLife

State Specific Fraud Warning Statements

ManhattanLife

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia: Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

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.

Arkansas, Louisiana, 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.

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 statement 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

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.

Kentucky, 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.

Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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.

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 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 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.

Virginia: Any person who, with the 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 the state law.