ManhattanLife™

VB Disability Claim Form - Employee Statement

Employee's Name_____ Policy No. _____

Date of Birth____/____/____ Mailing Address_____

City_____ State_____ Zip Code_____

Daytime Phone No.(___)_____

Is this a new address? ☐ Yes ☐ No

Primary Care Physician's Name_____

Address_____

Phone Number (_____)_____

Employer's Name_____ Occupation_____

List the job duties/responsibilities of your occupation at the time of the disability **(and submit a job description):**

_____

_____

Is the disability related to:

Pregnancy ☐ Yes ☐ No (**If Yes** and prior to delivery, please submit medical records and flow charts)

Accident ☐ Yes ☐ No (**If Yes** and the accident was related to a Motor Vehicle Accident, please submit police report)

Illness/Non-Routine Care ☐ Yes ☐ No

Describe the onset and nature of your illness or describe how and where the accident occurred:

_____

_____

_____

What aspect of your condition made you unable to perform your job:

_____

_____

Date that the first symptoms of the illness occurred or the date of accident___/___/____

Date you were first treated ___/___/_____

First date you were unable to work as a result of your disability___/___/_____

Did your injury or illness occur at work or as a result of your job? ☐ Yes ☐ No

If yes, did you inform your employer? ☐ Yes ☐ No

Reported To:

Employer Representative Name_____

Address_____ Phone No.(___)_____

If work related, please explain_____

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? ☐ Yes ☐ No

Mail to:
ManhattanLife VB Claims
PO Box 926169
Houston, TX 77292

Customer Service: 1-855-448-6982
Fax: 1-502-405-7107
Email: vbclaimssubmissions@manhattanlife.com

VB Disability Claim Form - Employee Statement

Have you returned to work? ☐ Yes ☐ No If yes, date returned___/___/___ Full-time ☐ Part-Time ☐

Are you employed with any other company other than the Employer listed above? ☐ Yes ☐ No
(If yes, please submit Disability Employer Statements from **ALL** employers)

Employer_____ Occupation_____
Dates Worked_____ Phone No. (____) _____

Physician information:
Attending (Treating) physicians:

Physician's Name	Address	Phone / Fax Number

Have you ever been treated for the same or a similar condition in the past? Yes ☐ No ☐
If yes, provide the prior Physician's Information:

Physician's Name	Address	Phone / Fax Number

Other Income Information:
Please indicate any additional income you are currently receiving:

Yes	No	Type	Amount	Frequency	Date Began	Date Ceased
☐	☐	Social Security(Disability or Retirement)	$____	_____	__/__/__	__/__/__
☐	☐	State Disability	$____	_____	__/__/__	__/__/__
☐	☐	Retirement (normal, early or disability)	$____	_____	__/__/__	__/__/__
☐	☐	Worker's Comp/Occupational Disease	$____	_____	__/__/__	__/__/__
☐	☐	Group Disability	$____	_____	__/__/__	__/__/__
☐	☐	Salary	$____	_____	__/__/__	__/__/__

If you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above?
☐ Yes ☐ No

Benefit Type_____ Date Applied___/___/___
Benefit Type_____ Date Applied___/___/___

Deduction of Premium

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

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

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

Signature of Employee _____ Date _____

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 11)

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

Signature of Policyholder _____ **Date** _____

- **Sign and date the authorization on page 7 and include when returning the claimform**
- **If the disability date is within the first year of the policy, complete the information on page 4 and return with the claim form.**

If the claim is being filed for a disability within the first year of the policy, complete both the physician and medication information below:

Physician information:

List all physicians that treated the patient in the five years prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

Medication information:

List all medication being taken by you:

Medication	Prescribing Physician	Date Prescribed

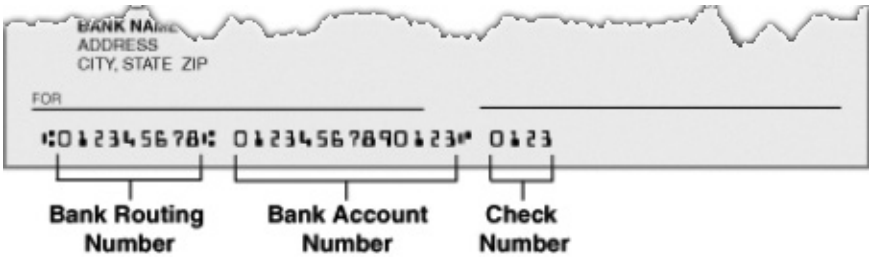
Direct Deposit Authorization

ManhattanLife™

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

Bank Name_____

Bank Routing Number_____ Bank Account Number_____



Policy Holder's Name _____

Policy No._____

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 Insurance Co., **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 Insurance Company 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 Insurance Co. or cannot be made to your account, ManhattanLife Insurance Co. 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 Insurance Co. **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 Insurance Company 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 Date

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

_____ _____

Signature Date

Mail to:
ManhattanLife VB Claims
PO Box 926169
Houston, TX 77292

Customer Service: 1-855-448-6982
Fax: 1-502-405-7107
Email: vbclaimssubmissions@manhattanlife.com

Authorization to release information - For the Use and Disclosure of Protected Health Information

Patient's Name_____**Policy No.** _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information to ManhattanLife Insurance Company,
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of ManhattanLife Assurance Company of America or ManhattanLife Insurance Company to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Attn: Claims Department PO Box 926169 Houston, TX 77292 . This revocation shall become effective on the date it is received by ManhattanLife Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

I certify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected health information as contemplated herein for ☐ all records or ☐ records for dates of service_____to_____

_____	_____	_____/_____/_____
Signature	*Printed Name*	*Date*

I have legal authority* under the laws of the State of_____to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies and execute this Authorization in my capacity as Authorized Representative thereof.

_____	_____	_____/_____/_____
Name of Authorized Representative/Parent or Guardian	*Relationship to Applicant*	*Date*

**A copy of the legal authority document must be on file with ManhattanLife.*

VB Disability Claim Form – Employer Statement

All questions must be completed by your Supervisor or an authorized Personnel Dept. staff member.

Employee Information:

Employee's Name_____ Date of Birth _____

Policy No._____ Current Annual Salary_____

Claim Information:

Date Employee Last Worked ___/___/___

Reason for stopping work: ☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Accident ☐ Dismissed
☐ Resigned ☐ Retired ☐ Other

Has the employee returned to work? ☐ Yes ☐ No ☐ Part-time Date
☐ Full-time Date

If No, what is the anticipated return to work date ___/___/___

Is this a Section 125 Plan? (If YES is selected taxes will be taken out of the employee's disability checks) ☐ Yes ☐ No

Employee's percentage of premium contribution: Employee pays_____% Employer pays_____%

Is the Employee receiving any form of salary continuance while on disability? ☐ Yes ☐ No

If yes, weekly benefit amount_____ Date benefits cease___/___/___

Is the Employee's condition work related or did the injury occur at work? ☐ Yes ☐ No

If Yes, has a Worker's Compensation or Occupational Disease claim been filed? ☐ Yes* ☐ No

*if yes, include a copy of the accident report

Is the Employee allowed to work from their home? ☐ Yes ☐ No

Is their light work available for the Employee to do? ☐ Yes* ☐ No

*if yes, explain on the line below

Explain:_____

_____

What are the major tasks of the Employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks. Also, submit a job description.

_____ _____ %

_____ _____ %

_____ _____ %

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Applications or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State specific fraud statements on page 11).

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

Employer's Name_____ Phone No. (___)_____

Address_____ Fax No. (___)_____

Printed Name of Person Completing Form_____

Signature of Authorized Representative_____

Title_____ Email_____ Date _____

VB Disability Claim Form -Physician Statement

Disability Information:

Patient's Name_____Date of Birth_____Height_____Weight_____

Is the disability related to: ☐ Illness ☐ Pregnancy ☐ Accident ☐ Mental/Nervous Condition

Date you advised the patient they should cease work:___/___/_____

If pregnancy, estimated date of delivery:___/___/____Date___/___/_____ ☐ Vaginal ☐ Cesarean Section

For conditions other than pregnancy , the date symptoms first appeared, or accident occurred:___/___/_____

Is the condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown

Treatment Information:

Diagnosis (including any complications)_____

Diagnosis Code(s) (ICD-9/10)_____If mental health diagnosis, complete the DSM-IV-TR axis 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 Patient's first visit for this condition ___/___/____ Date of last patient visit___/___/___

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other(specify)_____

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

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

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

Current treatment plan for this condition (including any rehab program/medications)_____

_____

Have any medications been changed? ☐ Yes ☐ No If yes, Date changed___/___/___

Medication change:_____

Have any surgeries already been performed? ☐ Yes ☐ No If yes, Date___/___/___

CPT Code(s)/procedure performed_____

If No, are there any surgeries scheduled? ☐ Yes ☐ No If yes, Date___/___/___

CPT Codes(s)/procedure scheduled_____

Has the patient been hospital confined? ☐ Yes ☐ No If yes, Date___/___/___

Discharge Date___/___/____

Hospital Name:_____Address_____

Has the patient ever had the same of similar condition? ☐ Yes ☐ No

If yes, indicate the type of condition, treatment date(s) and treatment provided:_____

_____

Please provide the name and address of other treating physician(s):

Physician's Name	Address	Phone Number

VB 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)
To be completed for cardiac disability ☐ 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 (To be completed for Mental Health disabilities)

- ☐ 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 on an average working day.

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	☐	☐	☐	☐	☐	☐	☐	☐

VB Disability Claim Form - Physician Statement

Patient Name_____Date of Birth_____

Prognosis and Restrictions:

Is the patient currently disabled from their job? ☐ Yes ☐ No

If the patient works from their home, would this change their disability status or length of the disability?

☐ Yes ☐ No

If yes, please explain:_____

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 in the patient's regular occupation?__/__/__ ☐ Full-time ☐ Part-time

What date can employment resume in another occupations?__/__/__ ☐ Full-time ☐ Part-time

If the return to work date is unknown at this time, please indicate date of next appointment:__/__/__

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

*** For pregnancy related disability: If filing disability prior to delivery, please submit medical records and flow charts.**

_____

_____

_____

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 11)

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

Printed Name of Physician_____Phone No. (___)_____

Specialty_____Tax Id_____

Address_____City_____

State_____ZIP Code_____Fax No. (___)_____

Email Address_____

_____ _____

Signature of Physician Date

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.