Workplace Voluntary Continuing Disability Claim Form - Employee Statement

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as “We" or “ManhattanLife.”

Life, Specified Disease/Critical Illness, Hospital Indemnity, and Accident Insurance products insured by ManhattanLife Assurance Company of America, Manhattan Life Insurance Company.

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 pages 2-3)

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

____ _____/_____/_____

Signature of Policyholder Date

Employee Information:

Policyholder’s Name ______________________________ Policy No. ________________

Mailing Address City ______________________________ Social Security No. ________________

________________ State ____________ ZIP Code __________ Date of Birth _____/_____/_____

Daytime Phone number (______) ______________________________

Since your disability, have you been able to perform any work? ☐ Yes ☐ No If yes, please complete the following:

Employer ______________________________ Occupation ______________________________

Dates worked: ____

Have you returned to work? ☐ Yes ☐ No If yes, date returned: _____/_____/_____ ☐ Full Time ☐ Part Time

Anticipated Return to Work Date: _____/_____/_____

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

Employer ______________________________ Occupation ______________________________

Dates worked: ______________________________ Telephone No (___) ______________________________

Deduction of Premium:

If your policy is currently active, <u>we will deduct premiums from your disability benefit</u> to keep your premiums paid to date. This will eliminate the risk that your policy be terminated for lack of premium payments.

If you do not want premiums deducted from your benefit, select the waiver option below, then sign and date your request.

☐ I **do not** want premiums deducted from my disability benefit.

____ _____/_____/_____

Signature of Employee *Date*

Mail to: ManhattanLife
PO Box 926169
Houston, TX 77092

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

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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.

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State Specific Fraud Warning Statements

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:

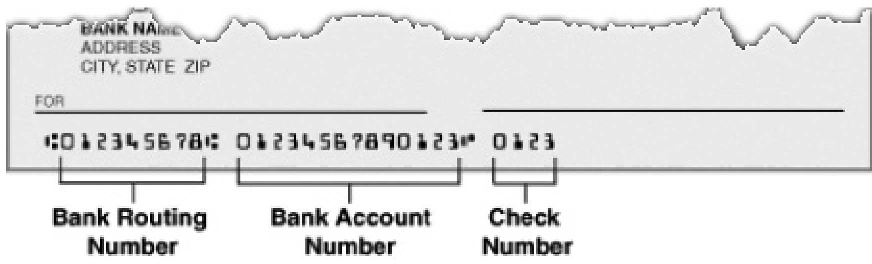
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Direct Deposit Authorization

Check Action			Effective Date			Acct. Type		Ownership of Account		
☐	☐	☐	__ __ -	__ __ -	__ __ __ __	☐	☐	☐	☐	☐
New	Change	Cancel	Month	Day	Year	Checking	Savings	Self	Joint	Other

Bank Name ____

Bank Routing Number ________________________ Bank Account Number ____________________



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 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

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 cancelled 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, ManhattanLife 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 cancelled by your financial institution or ManhattanLife. **Your participation will be cancelled automatically if you terminate participation in the above Account(s).**

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Workplace Voluntary Continuing Disability Claim Form - Physician Statement

Patient Information:

Employee's Name__________ Policy No. __________
Mailing Address__________ Social Security No. __________
City________ State________ ZIP Code________ Date of Birth____/____/____
Daytime Phone number (_____)__________ Height______ Weight______

Treatment Information:

Current Diagnosis (including any complications) & symptoms __________
Diagnosis Code(s) (ICD-9; ICD-10)__________ (If a 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 patient 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____/____/____ CPT Code(s)/ procedure performed __________
Has patient been hospital confined? ☐ Yes ☐ No
If "Yes", Admit Date____/____/____ Discharge Date____/____/____
Hospital Name:__________ Address __________

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__________

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Impairment continued:

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 10 lbs	☐	☐	☐	☐	☐	☐	☐	☐
11 to 20 lbs	☐	☐	☐	☐	☐	☐	☐	☐
21 to 50 lbs	☐	☐	☐	☐	☐	☐	☐	☐
51 to 100lbs	☐	☐	☐	☐	☐	☐	☐	☐

Prognosis and Restrictions:

Is 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 at this time, please indicate date of next appointment.______/______/______

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

____
____
____
____
____

Additional Comments:

____
____
____
____
____

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

Printed Name of Physician ______________________ Phone No. (   ) ______________

Street Address ______________________ Specialty ______________

City ______________ State ______________ ZIP Code ______________ Tax ID ______________

Email Address ______________________ Fax No. (   ) ______________

Signature of Attending Physician* ______________________ Date ____/____/____

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

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