## Maternity Express 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."

 $Life, Specified\ Disease/Critical\ Illness, Hospital\ Indemnity, and\ Accident\ Insurance\ products\ insured\ by\ Manhattan Life.$ 

Employ	yee Information:				
Employe	e's Name_ ne change, provide a copy of an updated driver's license, gover			Policy Number	
(If this is a nam Mailing A	ne change, provide a copy of an updated driver's license, gover Address	nment issued ID, marriage li	cense or divorce decree.)	Social Security N	0
	State				
Daytime	Phone number		Please check	if change of add	ress
	r's Name				
Physical V	Nork Location (City & State):			Years at Loca	ation:
	Worked:				
	Physician's Name				
11catilig 1	Physician's Phone Number			_	
Yes No	Туре	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				
	Group Disability Salary				
	•	\$			
Y	Salary not receiving these benefits, do you plan	\$on applying or have	e you applied for		d above?

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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.

Yes, I do want premiums deduc	ted from my disability benefit.	
No, I do not want premiums de	ducted from my disability benefit.	
Signature	Printed Name	Date
	aud or knowing that he/she is facilitating a fi false or deceptive statement may be subject ad Warning Statements on page 4)	
The above Statements are true to t	he best of my knowledge and belief.	
Signature	Printed Name	

### **Authorization to Release Information**

For the Use and Disclosure of Protected Health Information



Pa	tient's NamePolicy No
dei Ind	: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or atal services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The lex System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or cal Government Agency, including Social Security Administration and Veterans Administration.
	authorize the use and/or disclosure of my protected health information and other related information as scribed 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
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 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. 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.

Signature	Printed Name	 Date	
I have legal authority* under the laws of the Sta , the individual to whapplies and execute this Authorization in my capa	om the use and/or discl	to make health care decisions on behasclosure of protected health information above presentative thereof.	
Name of Authorized Representative/Parent or Guardian	Relationship to Appl	oplicant Date	—

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

## **Direct Deposit Authorization**

AccountTypo

Chook Action



Officeraction	racount type	ownersing or recount
New Change Cancel C	hecking Savings	Self Other Policy Number_
•		1 oney 1 diliber
		Bank Account Number
Account Holder's Name		
	Bank Routing Number  Bank Account Number	unt Check

Ownership of Account

### 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, 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 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

# <u>Maternity Express Disability Claim Form</u> <u>Physician Statement</u>



Patient Name	Date of Birth		
Disability Information:			
Date of Delivery:	Delivery Type: □Vaginal □ C-section		
First date the patient was treated for the			
Estimated date of inception (Conception)			
	ud or knowing that he/she is facilitating a fraud against an insurer, submits an false or deceptive statement may be subject to prosecution and punishment for d Warning Statements on page 4)		
The below Statements are true to t	the best of my knowledge and belief		
	Phone No		
	City		
	Tax ID		
	Fax No		
Signature of Attending Physician*	Date		
*Note form must be signed by medical do	octor duly licensed in the state where services are rendered		
<b>Maternity Express Dis</b>	gability Claim Form		
	bability Claim Form		
<b>Employer Statement</b>			
Employee's Name	Policy No		
Date of Birth	Employee Last Worked		
	cted taxes will be taken out of member's disability checks) Yes No		
Employee's percentage (%) of premium of	contribution: Employee pays		
Current Annual Base Salary*	*Not including overtime pay, bonuses, commissions, or extra compensation  Yes No		
If yes how much did the employee make	e in commissions in the last 12 calendar months?		
-			
	ud or knowing that he/she is facilitating a fraud against an insurer, submits an false or deceptive statement may be subject to prosecution and punishment		
for insurance fraud. (See State Specific F			
The above Statements are true to t	he best of my knowledge and belief		
	Phone No		
	Fax No.		
	1		
	•		
Title			

#### 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 information to obtain or amend insurance coverage or to make a 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.