Workplace Voluntary 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 3-4)

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

_____ _____/_____/_____

Signature of Policyholder Date

Employee's Name _____ Policy No. _____

Mailing Address_____ Date of Birth _____/_____/_____

City_____State_____Zip Code_____Daytime Telephone No. (_____) _____

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 priory 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 ☐Yes ☐No

Date of the first symptoms of the illness or 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 result of your job? ☐ Yes ☐ No

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

Reported to:

Employer Representative Name_____

Address _____ Telephone No. (_____) _____

If work related, please explain _____

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

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

_____

_____

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

_____

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?

☐ No ☐ Yes (if yes please submit employer statements from ALL employers)

Employer _____ Occupation _____

Dates worked: _____ Telephone 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, Please provide the prior physician 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	$_____	_____	____/____/____	____/____/____

f you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above?

☐ Yes ☐ No

Type _____ Date Applied: _____/_____/_____

Type _____ Date Applied: _____/_____/_____

Deduction of Premium

If your policy is currently active, we will deduct premiums from your disability benefit 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_____/_____/_____

- **Sign and date the authorization on page 5 and include when returning the claim form**
- **If the disability date is within the first year of the policy, complete the information on page 3 and return with the claim form.**

State Specific Fraud Warning Statements

ManahattanLife:

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

State Specific Fraud Warning Statements

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.

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:

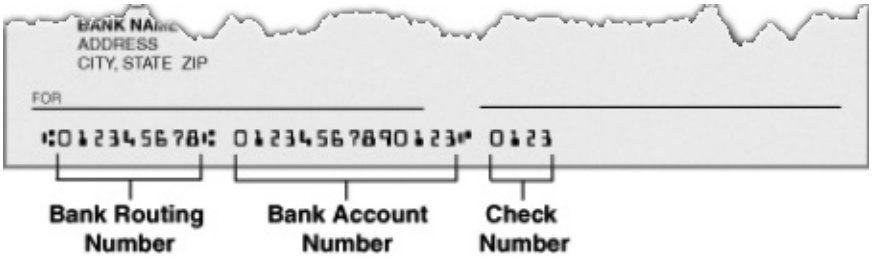
Medication	Prescribing Physician	Date Prescribed

Direct Deposit Authorization

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 Kanawha 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

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 Kanawha Insurance Company, **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 Kanawha 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 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 Kanawha Insurance Company or cannot be made to your account, Kanawha Insurance Company 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 Kanawha Insurance Company. **Your participation will be cancelled automatically if you terminate participation in the above Account(s).**

ManhattanLife
Since 1850

Mail to the following address:

ManhattanLife Claims
PO Box 926169
Houston, TX 77092

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

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

Patient's Name _____Contract No._____

To: Any Medical, health proffessional, 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 Assurance Company of America, Manhattan Life 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, Manhattan Life 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 Assurance Company of America or Manhattan Life Insurance Company PO Box 926169 Houston, TX 77092. This revocation shall become effective on the date it is received by ManhattanLife Assurance Company of America or Manhattan Life 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 ManahattanLife.*

Workplace Voluntary Disability Claim Form - Employer Statement

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

Employee Information:

Employee's Name _____ Date of Birth _____ /_____/_____

Social Security No. _____ 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 employee returned to work? ☐ Yes ☐ Part-time Date ____ /____/_____
☐ Full-time Date ____ /____/_____
☐ No ☐ 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 member's disablity 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

Has Workers' 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 there light work available for the employee to do: ☐ Yes ☐ No
(If yes, explain on line below)

If "yes" 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? (**and submit a job description**)

_____ _____%

_____ _____%

_____ _____%

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

Employer's Name _____ Telephone Number (_____)_____

Address _____ Fax Number (_____)_____

Printed Name of Person Completing Form _____

Signature of Authorized Representative _____

Title _____ Email_____ Date _____ /_____/_____

Mail to the following address:

ManhattanLife Claims
PO Box 926169
Houston, TX 77092

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

Workplace Voluntary 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____ /____/_____

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; 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 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", Surgery Date ____ /____/_____

CPT Code(s)/ procedure performed_____

If "No", are any surgeries scheduled? ☐ Yes ☐ No ☐ If "Yes", Scheduled Date ____ /____/_____

CPT Code(s)/ procedure scheduled _____

Has patient been hospital confined? ☐ Yes ☐ No ☐ If "Yes", Admit Date ____ /____/_____

Discharge Date ____ /____/_____

Hospital Name: _____ Address _____

Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ If "Yes", indicate 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

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 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

If the patient works from their home, would this change their disability status or the length of 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 patients regular occupation? ____ /____/_____ ☐ 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. ____ /____/_____

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

If filing for disability prior to delivery please submit medical records and flow charts.

_____

_____

_____

_____

Life expectancy: ☐ 6 months or less ☐ 9 months or less ☐ 12 months or less ☐ Greater than 12 months

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