



A Guide for Successfully Completing the Group Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure all required information is provided and all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Guidelines for Section 1: Employee's Statement

This section is to be completed by the Employee. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About You

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.
- Provide weight in pounds, and height in feet and inches.
- Your Occupation/Job Title is the title of your position held with the employer.
- Indicate any other Mutual of Omaha/United of Omaha plans in which you are currently insured.

C. Information About Your Disabling Condition

- The Date First Treated is the date you first sought out medical care because of the disabling condition.

D. Information About Work

- The Last Day Worked is the day before you were first absent from work because of the disabling condition.

E. Information About Care and Treatment

- Provide the name, specialty, phone and address for each doctor or hospital that treated you for the disabling condition.

F. Information About Other Income Benefits

- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/United of Omaha.
- Check all sources of other income that apply.

G. Information for Tax Withholding

- If your claim is paid, indicate whether or not you would like Mutual of Omaha to withhold income tax from your benefit payment, and if so, how much. Minimum is **\$88** per month.

H. Signature

- Your signature is required.

Education, Training and Work Experience

- This form is to be completed by the employee. Please make sure all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Vocational rehabilitation services include, but are not limited to (a) job modification; (b) job placement; (c) retraining; and (d) other activities reasonably necessary to help you return to work.

Authorization to Disclose Personal Information

This authorization is to be completed by the employee.

- Please read this section in its entirety. By signing the authorization, you are applying for long-term disability benefits with Mutual of Omaha/ United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.
- **IMPORTANT:** To be complete, the form must be signed by you.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employer

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers.

B. Information About the Employee

- The Date Employee Became Insured Under This Plan indicates the date in which the employee's coverage became effective.
- The Date Employee Became Insured Under Prior Plan indicates the date in which the employee's coverage was in effect under a plan prior to the Mutual of Omaha plan.
- The No. of Hours Employee Regularly Works is the number of hours the employee is typically at work per day/per week for the employer.

C. Information for Tax Withholding

- If this section is not completed, Mutual of Omaha will assume that premium paid by the employee is with pre-tax dollars.
- If this is not true, indicate otherwise and provide the percentage amount.

E. Information for Life Waiver

- Date Life Insurance Terminated means the first day the coverage is no longer in force.
- If applicable, the Paid-To-Date for group life insurance is the date on which the next premium is due.

F. Information About Your Pension Plan

- This section is not applicable if the disabling condition is maternity.

H. Information About Employee's Salary

- Indicate the method in which the employee is paid.
- If hourly, also indicate the hourly rate in which the employee is paid.
- Please attach supporting payroll documentation.

Guidelines for Section 3: Job Analysis

This section is to be completed by the employer if a formal job description is not available. If a formal job description is not available, please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employee's Job

- Occasionally means the employee does this activity up to 33 percent of the time.
- Frequently means the employee does the activity 34 percent to 66 percent of the time.
- Continuously means the employee does the activity 67 percent to 100 percent of the time.

B. Physical Aspects of the Job

- Check all the activities that apply to the employee's job.
- Indicate the frequency with which the employee performs the activity using the guidelines in Section A, Information About the Employee's Job.

Guidelines for Section 4: Signature and Attachments

- Attach a copy of the employee's job description to the claim application.
- Attach any additional documentation that may be helpful when reviewing the application, including further explanation of any question(s) on the application.
- Your signature is required.

Guidelines for Section 5: Attending Physician's Statement

This section is to be completed by the attending physician. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: 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.

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/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee: Any person who, with 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 is guilty of insurance fraud.

California: For your protection California law requires the following to appear on this form: 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.

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.

Kansas: 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 as determined by a court of law.

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 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.

Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed 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 on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: 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 penalties.

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 state law.

Disability Claim Form

3300 Mutual of Omaha Plaza | Omaha, NE 68175-0001
Phone (800) 877-5176 (toll-free) | Fax (402) 997-1865
Email newdisabilityclaim@mutualofomaha.com

What type of disability coverage do you have?

Short-Term Disability Long-Term Disability Both

Section 1 - Employee's Statement (Answer all questions to avoid delay.)

A. Information About You

Employee Last Name Employee First Name Employee Middle Initial Group Policy Number

Employee Address Employee City Employee State/Province Employee ZIP

Employee Telephone () Employee Email Address Employee Social Security Number

Employee Date of Birth Height Weight Male Right Handed Single Widowed
 Female Left Handed Married Divorced

Name of Your Employer (include Division/Location, if applicable) Your Occupation/Job Title

Under what other Mutual of Omaha/United of Omaha policies are you currently covered? Did you have disability coverage prior to being effective with Mutual of Omaha? Yes No

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 31 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the internet or from your employer.

B. Information About Your Family (Required to determine your eligibility for Social Security benefits.)

Spouse's Name Spouse's Social Security Number Spouse's Date of Birth Is your spouse employed? Yes No

First and Last Name of any children under the age of 25 Date of Birth Social Security Number

C. Information About Your Disabling Condition

1. If your disability is due to an injury, answer the following questions and then proceed to #3 below.

When did the injury occur?

Where and how did the injury occur?

What is the date you were first treated by a physician?

2. If your disability is due to a pregnancy or an illness, answer the following questions. If **not** pregnancy-related, proceed to #3 below.

What were your first symptoms?

When did you notice these symptoms?

What is the date you were first treated by a physician?

3. If your disability is due to an injury or an illness, but not pregnancy, answer the following questions.

Why are you unable to work?

Before you stopped working, did your condition require you to change your job or the way you did your job? Yes No If **Yes**, please explain below.

Is your condition related to your occupation? Yes No If **Yes**, please explain below.

Have you filed, or do you intend to file a Workers' Compensation claim? Yes No

D. Information About Work

What is the date of your last day worked before the disability? On your last day worked, did you work a full day? Yes No
If **No**, please explain.

What is the date you were first unable to work? Have you returned to work? Yes, Part-Time Yes, Full-Time No
What date did you return to work?

If you haven't yet returned to work, do you expect to? Yes, Part-Time Yes, Full-Time No

What date do you expect to be able to return to work?

Are you currently self-employed or working for another employer? Yes No If **Yes**, provide details.

E. Information About Care and Treatment (If additional space is needed, please provide details on a separate page.)

Doctor who first provided medical attention to you for your current disability.	Doctor's Specialty	Telephone () Fax ()
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

List all other physicians and/or hospitals you have visited for this condition below.

Doctor's Name	Doctor's Specialty	Telephone () Fax ()
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

Doctor's Name	Doctor's Specialty	Telephone () Fax ()
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

Doctor's Name	Doctor's Specialty	Telephone () Fax ()
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

Name of Hospital	Department of Treatment	Telephone () Fax ()
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

Name of Hospital	Department of Treatment	Telephone () Fax ()
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

F. Information About Other Income Benefits (Check all benefits you are receiving or are eligible to receive.)

Source of Income	Amount	Weekly/Monthly	Date claim was filed	Date payments began	Date payments ended
Social Security Retirement	_____	_____	_____	_____	_____
Social Security Disability	_____	_____	_____	_____	_____
Canadian Pension Plan	_____	_____	_____	_____	_____
Workers' Compensation	_____	_____	_____	_____	_____
State Disability	_____	_____	_____	_____	_____
Pension Retirement	_____	_____	_____	_____	_____
Pension Disability	_____	_____	_____	_____	_____
Short-Term Disability	_____	_____	_____	_____	_____
Unemployment	_____	_____	_____	_____	_____
No-Fault Insurance	_____	_____	_____	_____	_____
Other (include Individual or Group benefits)	_____	_____	_____	_____	_____

G. Information For Tax Withholding

If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks? Yes No
 If **Yes**, how much should be withheld from each check (the minimum is **\$88.00** per month). \$ _____ .00

Overpayment Notice: Should you become overpaid at any time during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

H. Signature (Required for all claims.)

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.

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

X _____
 Signature of Employee _____
 Date

Education, Training and Work Experience

Name _____

Policy Number _____

Claim Number _____

Educational BackgroundHigh School Graduate: Yes No If **No**, what was the last grade completed? _____ Last Date Attended _____GED: Yes No Field of Study: General Business Vocational OtherDid you attend college? Yes No Last Date Attended _____Name and Address of College _____

Major(s) _____

Final Status: Freshman Sophomore Junior Senior Undergraduate Degree Graduate School

Degree(s) earned _____

Other formal training _____

Certification(s) _____

Computer Skills _____

Military Service: Yes No If **Yes**, in which branch did you serve? _____

Rank _____

Specialty _____

What computer programs are you able to use? _____

List all languages spoken fluently _____

Work Experience

Please fill out completely. Start with your most recent employment and list chronologically.

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? Yes NoReason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? Yes NoReason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? Yes No

Reason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? Yes No

Reason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? Yes No

Reason for leaving? _____

Additional courses taken, hobbies and special skills. Please be specific such as computer skills either personal or professional, sales, carpentry, auto repair, etc.

Are you currently involved in a vocational rehabilitation program? Yes No

If **Yes**, please provide the name, address and phone number of the rehabilitation case worker _____

Are you interested in learning about our vocational rehabilitation program? Yes No

What is your employment goal or other work that you would be interested in doing? _____

Date _____ **Signature** _____

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

Name of Claimant _____
(Last) (First) (Middle)

Date of Birth ____/____/____ Social Security Number ____-____-____

2. Personal Information to be released:

- data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
- any information regarding insurance or benefit plan coverage, claims or benefits; and/or
- any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. You may release my Personal Information to:

Group Disability Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
or Fax: 402-997-1865 or Email: newdisabilityclaim@mutualofomaha.com

4. I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:

- to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
- to a vendor specializing in the application for Social Security Disability Benefits; or
- to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
- for self-insured disability plans only, to my employer; or
- for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
- as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

Signature of Claimant

Date

If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

This page was left intentionally blank.

Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Accident Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued by United of Omaha to my financial institution with the information provided below, for credit to my account. Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.

I further understand and agree that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.

I further understand and agree for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.

I further understand and agree that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.

I further understand that if my bank is not able to accept EFTs, checks will be mailed to my residence.

I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	Bank Information
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ()	Telephone Number ()
Social Security Number	Account Number
Policy Number	Bank ABA Routing/Transit Number
Claim Number	<input type="checkbox"/> Checking <input type="checkbox"/> Savings <i>(Check only one)</i>
Payee Number (for office use only)	Approved By/Date (for office use only)

X _____ Date

Payee Signature

Contact Information

Please attach EITHER a **voided check for checking** OR a **deposit slip for savings** and return with this form to:

United of Omaha Life Insurance Company
HO8W-GDMS
3316 Farnam Street
Omaha, NE 68172-7420

Should you have any questions regarding EFT, please feel free to contact our customer service representatives toll free at **1-800-775-8805** (Monday-Friday between the hours of 8 a.m. and 4 p.m. CST).

This page was left intentionally blank.

Section 2 - Employer's Statement (Answer all questions to avoid delay.)

Employee's Name	Social Security Number	Date of Birth
Employee's Address	Employee's Phone Number	

A. Information About the Employer

Company's Name	Group Policy Number	Class Number or Description
Company's Address (Number, Street, City, State ZIP)	Company's Telephone ()	
	Company's Fax ()	
Name and Address of Location Where Employee Works	Location Number	Location Telephone ()
		Location Fax ()

B. Information About Employee

What type of disability coverage does the employee have? Short-Term Disability Long-Term Disability Both

Employee's Hire Date _____ Date Employee became insured under this plan _____ Number of hours Employee regularly works per day/per week? _____
Date Employee became insured under prior plan _____ # of hours per/week _____ # of hours per/day _____

C. Information for Tax Withholding

If this section is left blank, we will calculate FICA taxes based on the following assumption: 100% Employer contribution or any portion paid by Employee is paid with pre-tax dollars.

Does Employee contribute post-tax dollars toward the premium? Yes No If **Yes**, what percent is paid by Employee? _____% Post-Tax

D. Information About the Claim

Before Employee required leave of absence, were changes made to Employee's job responsibilities due to the disabling condition? Yes No

If Yes, please describe the changes and when they were made.

Date Employee Last Worked _____ Did Employee work a full day? Yes No
If **No**, how many hours were worked? _____

What was Employee's permanent job on his/her last day worked? _____ How long had Employee been in this job? _____

Why did Employee stop working? _____ Has Employee returned to work? Yes No
If **Yes**, when? _____

Is Employee's condition work related? Yes No Has a Workers' Compensation claim been filed? Yes No
If **Yes**, send initial report of illness/injury and award notice.

Name of Workers' Comp Carrier _____ Address of Workers' Comp Carrier _____ Contact Person's Name & Phone Number _____

E. Information for Life Waiver

Important Notice: If an Employee is age 60 or over, please refer to the policy provisions regarding group life continuation and conversion rights.

Is Employee covered under a Group Life policy with United of Omaha? Yes No
If **Yes**, what is the effective date of the life insurance plan? _____

F. Information About Your Pension Plan (Do not complete for maternity.)

Do you have a pension plan? Yes No If **Yes**, what type? Defined Benefit 401(k) Other (specify) _____
 Defined Contribution Profit Sharing

Is Employee eligible for your pension plan? Yes No If eligible, does Employee participate? Yes No
If **Yes**, when is Employee eligible for benefits under the pension plan? _____

If Employee is eligible but does not participate, explain why. _____

What percentage of their salary does the employee contribute to their pension? _____%

Does the Employee receive retirement/disability pension benefits? Yes No

If **Yes**, complete the following: Effective date of benefit _____ Monthly Amount? _____

G. Information About Your Rehire or Return to Work Policies

Does your company support rehire if unable to return to work beyond protected leave of absence? Yes No

Does your company support Transitional Return to Work while still on protected leave of absence? Yes No

Who should we contact if we identify a Transitional Return to Work option? Name/Title

Contact Number

H. Information About Employee's Salary (Please attach supporting payroll documentation.)

(Check all that apply) Employee is paid hourly (\$ _____ hourly rate) is salaried receives commissions receives bonuses

Will Employee file for disability benefits provided by any Employer/Employee Labor Management, State Disability or Union Welfare plan? Yes No

If **Yes**, please answer the following questions. Weekly amount? _____ Date benefits begin? _____ Date benefits end? _____

Is Employee eligible for Salary Continuation? Yes No If **Yes**, please answer the following questions.

Weekly amount? _____ Date benefits begin? _____ Date benefits end? _____

Is Employee eligible for Sick Leave? Yes No If **Yes**, please answer the following questions.

Weekly amount? _____ Date benefits begin? _____ Date benefits end? _____

Per the definition of Basic Monthly Earnings in your Policy, what are Employee's pre-disability monthly earnings?

Section 3 - Job Analysis (To be completed by the Employee's Supervisor or HR Department only if a formal job description is not available. If a formal job description is not available, please answer all questions to avoid delay.)

A. Information About Employee's Job

Job Title _____

Minimum education or training required? _____

How long will Employee's job be held open? _____

Does Employee perform supervisory functions? Yes No If **Yes**, how many people are supervised? _____

Describe Employee's job duties.

Indicate how each of the following related to Employee's job.

	Occasionally (0%-33%)	Frequently (34%-66%)	Continuously (67%-100%)
Computer use	_____	_____	_____
Relate to others	_____	_____	_____
Written and verbal communication	_____	_____	_____
Reasoning, math and language	_____	_____	_____
Make independent judgments	_____	_____	_____

Which of the following describe Employee's working environment? **Check all that apply.**

- Unprotected heights
- Changes in temperature
- Exposure to dust, fumes and gases
- Being near moving machinery
- Driving automotive equipment
- Other hazards (Please explain)

Is Employee required to travel? Yes No If **Yes**, please answer the following questions.

How does Employee travel? Automobile Plane Train Other

What percent of the time does Employee travel? _____%

Where does Employee travel?

B. Physical Aspects of the Job

Select how each of the following relates to Employee's job.

Activity	Frequency of Occurrence			
	Not Applicable	Occasionally (0%-33%)	Frequently (34%-66%)	Continuously (67%-100%)
<input type="checkbox"/> Standing	_____	_____	_____	_____
<input type="checkbox"/> Walking	_____	_____	_____	_____
<input type="checkbox"/> Sitting	_____	_____	_____	_____
<input type="checkbox"/> Balancing	_____	_____	_____	_____
<input type="checkbox"/> Stooping	_____	_____	_____	_____
<input type="checkbox"/> Kneeling	_____	_____	_____	_____
<input type="checkbox"/> Crouching	_____	_____	_____	_____
<input type="checkbox"/> Crawling	_____	_____	_____	_____
<input type="checkbox"/> Reaching/Working overhead	_____	_____	_____	_____
<input type="checkbox"/> Climbing stairs	_____	_____	_____	_____
<input type="checkbox"/> Climbing ladders	_____	_____	_____	_____
<input type="checkbox"/> Pushing/Pulling	_____	_____	_____	_____
<input type="checkbox"/> Lifting/Carrying	_____	_____	_____	_____

Section 4 - Employer's Signature and Attachments (Please Attach Employee's job description and additional documentation.)

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Print name of person completing this form _____

Title _____ Email Address _____

Telephone (_____) _____ Fax (_____) _____

Signature _____ Date _____

Section 5 - Attending Physician's Statement (Answer all questions to avoid delay.)

A. General Information

Patient's Name	Employer's Name	Policy Number		
Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth

B. Complete the following for normal pregnancy, then go to Section E.

Date of the patient's last menstrual period?	Expected date of delivery?	
Expected length of postpartum recovery?	First date of treatment?	Last date of treatment?

C. Complete the following for all conditions except normal pregnancy.

Primary diagnosis (including ICD-9 or DSM code)	Symptoms
What diagnostic testing has been done?	Objective Findings

Are there secondary conditions contributing to the patient's disability? Yes No
If **Yes**, what are they (include ICD-9 or DSM)?

If this is a cardiac condition, what is the functional capacity (American Heart Association)?

Ejection Fraction Class 1-No Limitation Class 2-Slight Limitation Class 3-Marked Limitation Complete Limitation

If this is a psychiatric condition, what is the current GAF/WHODAS score? In the past year, what was the patient's highest GAF/WHODAS score?

When did symptoms first appear?	Date of patient's first visit?	Date patient was first unable to work?
Date of patient's last visit?	How often do you see this patient?	

Is the patient's condition work related? Yes No If **Yes**, please explain.

Has patient undergone surgery or expected to have surgery in the future? Yes No If **Yes**, answer the following.

Date of surgery	Surgical Procedure	Result
-----------------	--------------------	--------

What medication is the patient currently taking or been prescribed?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program? Yes No If **Yes**, give details.

Have you referred the patient for other types of consultations? Yes No If **Yes**, give details.

Has the patient been hospital confined? Yes No If **Yes**, please complete the following.

Name of Hospital	Address of Hospital	Dates of Confinement
		From _____ To _____

D. Information About the Patient's Inability to Work

Briefly describe the patient's restrictions. (SHOULD NOT DO)

Briefly describe the patient's limitations. (CANNOT DO)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement? Yes No If **No**, please complete the following.

How soon do you expect fundamental changes in the patient's medical condition?

1-2 months 3-4 months 5-6 months 6 months to a year 1 year or more Never

Give details concerning expected improvement or deterioration.

What is your treatment plan for the patient's return to work or return to prior level of function?

In an eight-hour workday, the patient can: **(Check full hourly capacity for each activity.)**

Sit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Stand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Walk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

Are there restrictions in:	Yes	No	If Yes, please fully explain below.
Driving/Operating motorized equipment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting/Carrying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of hands in repetitive actions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of feet in repetitive movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time.

	Unlimited	Somewhat Limited	Markedly Limited	Unable to Perform
Follow work rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform repetitive, or short cycle work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform at a constant pace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain attention and concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform a variety of duties.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand, remember and carry out complex job instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attain set limits and standards.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relate to co-workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact with supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact with the public/customers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use judgment and make decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Direct, control or plan activities of others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influence people in their opinions, attitudes and judgments.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressing personal feelings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work alone or apart in physical isolation from others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Information About the Patient's Inability to Work (continued)

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

When do you expect the patient to return to prior level of functioning?

Would you recommend vocational rehabilitation for this patient?

Yes No

E. Required Attachments and Signature

After you have fully completed this form, please attach copies of the following materials.

- Office notes for the period of treatment received over the last two years
- Hospital discharge summaries
- Test results showing objective findings
- Consulting physician reports

Your Name

Degree

Specialty

Telephone ()

Fax ()

Address

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.

X _____
Signature of Attending Physician (no stamp)

Date