TOTAL AND PERMANENT DISABILITY BENEFITS APPLICATION

PLEASE PRINT

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 682-6768 • Fax: (202) 962-2939
Toll-free: (866) 795-0680

INSTRUCTIONS

1. The member must complete all questions on the application where indicated or his/her duly appointed legal representative if incompetent or totally incapacitated.
2. The Attending Physician Statement should be completed by the physician', all questions must be answered.
3. Please review form to make certain that all pertinent questions are answered before forwarding claim to avoid unnecessary delay in processing the claim.
4. Please submit completed ALL pages of this form.

Policyholder's Statement (To Be Completed by Plan or Fund Administrator Only)

Member was in Good Standing in this organization from_______________through __________________
(Date) (Date)

Name of Insured: ____________________________________ SSN ________________________________ Benefit Amount: $ ___________________

Policy No.: G______________Name of Policyholder: ____

We certify that the member was eligible for the insurance at the commencement of disability and that said insurance will terminate on_______________.
Date

Signature: ____
(Plan or Fund Administrator)

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PLEASE READ AND COMPLETE ALL PAGES

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FRAUD NOTICES

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.

California: For your protection California Law requires the following 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.

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.

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 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 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.

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.

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.

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.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

I attest that I have reviewed, understand and acknowledge the above Fraud Notice:

Signature: X________________________________ **Date:** __________________
Claimant or Duly Appointed Legal Representative

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TO BE COMPLETED BY MEMBER or LEGAL REPRESENTATIVE

Policy Number: G - ______________

Member's Name ______________ Name of Last Employer ______________

Home Address ______________ Address of Employer ______________

City, State Zip Code ______________ Telephone Number ______________ City, State Zip Code ______________

Date of Birth ______________ SSN ______________ Occupation ______________ Date Last Worked ______________

Do you expect to return to work: ☐ Yes ☐ No If Yes, When? ______________ Date

Date Disability Began ______________ Cause of Disability (if accident, please specify when and how it happened) ______________

Have you engaged in any occupation or business since the beginning of this disability?
If yes, please describe; ______________

Name of Present Physician ______________ Name of Hospital (if now, or during past year, confined) ______________

Complete Address ______________ Complete Address ______________

Date First Treated for this Disability ______________ Date Last Treated for this Disability ______________ Date Admitted ______________ Date Discharged ______________

If not hospitalized, were you confined to your:
HOUSE ☐ YES ☐ NO
BED ☐ YES ☐ NO

If not confined, what activities if any can you perform? ______________

Current Medical Conditions/Diagnosis – Primary ______________
Date 1st Symptom: ______________
Secondary Condition/Diagnosis ______________
Please describe your current medical limitations and why you are unable to do any work.

Is your condition showing improvement?

Give Name and Addresses of any other Physicians that can provide information on your Disability:
Name: ______________ Address: ______________ Telephone: ______________
Name: ______________ Address: ______________ Telephone: ______________

Give source and amount of present income derived from other than insurance policies: ______________
List insurance carrier under which you receive a Waiver of Premium or Income Benefit due to Disability ______________

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TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORAMTION BUREAU, EMPLOYERS AND OTHER PERSON OR INSTITUTIONS: This authorizes you to give to The Union Labor Life Insurance Company, or its authorized representative who is employed to assist in the evaluation of my claim, any information, data or records you have about me or my health, including medical history, diagnosis, prognosis, treatment of any physical or mental condition, and including information about a psychiatric condition or use of drugs or alcohol. Any non-medical information which is requested about me to determine my eligibility for insurance benefits, including such things as my education, employment history, other claims I have filed, and my eligibility for other benefits.

I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE USED TO DETERMINE MY ELIGIBILITY FOR INSURANCE BENEFITS. I understand and agree that his authorization will remain in force throughout the duration of my claim for benefits from The Union Labor Life Insurance Company. I agree that a photocopy of this authorization may be used to obtain information. I understand that additional copies will be provided to me upon request. I hereby Certify that the answers above are true and complete to the best of my knowledge.

Signature of Insured or Duly Appointed Legal Representative: ___________________________Date: ______________________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

Authorization to Obtain and Disclose Information

I hereby authorize all of the people and organizations listed below to give The Union Labor Life Insurance Company and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize the following entity to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility
- any insurance or reinsurance company (including the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage)
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIS).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits and contestability of a health insurance policy.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Union Labor Life Company Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: The Union Labor Life Insurance Company, 8403 Colesville Road Silver Spring, MD 20910. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_______________________________	_______________________________
Name of Insured	Date
Signature of Insured or insured's Personal Representative	Description of Authority of Personal Representative (if applicable)

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Attending Physician's Statement

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Attending Physician's Statement of Disability * * THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**

Patient Name: ______ **Age:** ______ **SSN last 4 digits:** ______
Present Address: ______ **City:** ______ **State:** ____ **Zip Code:** ______

History

Date when symptoms first appeared or accident happened: ______ Date patient ceased working because of disability: ______

Has the patient ever had a similar condition? ☐ Yes ☐ No If yes, please describe: ______

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

Names and address of other treating physicians: ______

Diagnosis (including any complications)

Date of Last examination: ______ Diagnosis (including any complications): ______

Secondary Diagnosis (if applicable) ______

Subjective Symptoms: ______

Objective findings (including X-rays, EKG's, Laboratory Date and any clinical findings): ______

Dates of Treatment

Date of first visit: ______ Date of last visit: ______

Frequency of visits: ☐ Weekly ☐ Monthly Other (Specify) ______

Nature of Treatment (including Surgery and medications prescribed, if any) ______

Progress

Patient's Condition: ☐ Recovered ☐ Improved ☐ Unchanged
The patient is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined

If Hospital Confined, please give name and address of hospital: ______

Dates Confined from ______ through ______

Specify current condition on following:

I. Cardiac
Functional Capacity: ☐ Class 1 (No Limitations) ☐ Class 2 (Slight Limitations) ☐ Class 3 (Marked Limitations) ☐ Class 4 (Complete Limitations)
Blood Pressure (last visit) ______

II. Visual
If the claim is for loss of sight, what is the patient's visual acuity? ______ Is the loss total and permanent? ☐ Yes ☐ No
Is the loss due to the accident? ☐ Yes ☐ No If so, to what degree? ______

III. Physical
☐ Class1 – No limitation of functional capacity; capable of heavy work. No restrictions (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; incapable of minimal (sedentary) activity (75-100%)

Remarks: ______

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Attending Physician's Statement of Disability **THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**
(Continuation)

Patient Name: ______________________ **Age:** __________ **SSN last 4 digits:** __________

IV. Mental/Nervous

- ○ 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 situation and engage in most interpersonal relations (slight limitations)
- ○ Class 3 – Patient is able to engage in only limited stress situations and 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)

Remarks ______________________________

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Prognosis

Is patient now totally disabled? ☐ **Yes** ☐ **No**	**PATIENT'S CURRENT OCCUPATION**	**ANY OTHER OCCUPATION**
What duties of patient's job is he/she incapable of performing?	__________	__________
Do you expect a fundamental or marked change in the future?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, when will patient recover sufficiently to perform duties?	Date: __________	Date: __________

If no, please explain: ______________________________

☐ 1 Month ☐ 1 – 3 Months ☐ 3 – 6 Months ☐ 6 – 9 Months ☐ 9 – 12 Months ☐ NEVER

Rehabilitation

Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc) ☐ Yes ☐ No

Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

	PATIENT'S CURRENT OCCUPATION	ANY OTHER OCCUPATION
When could trial employment commence?	Date: __________	Date: __________
	☐ Full Time ☐ Part Time	☐ Full Time ☐Part Time

Would vocational counseling and/or retraining be recommended: ☐ Yes ☐ No

Remarks: ______________________________

Print Physician Name: __________ **Specialty:** __________

Address: ______________________________

City: __________ **State;** ______ **Zip Code:** ______ **Telephone Number:** __________

Signature: X __________ **Date Signed:** __________