



Long Term Disability Claim Statement --- Conversion

ASSURANT
Employee
Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:

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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:

A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:

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.

If you live in the state of California, the following statement applies to you:

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.

If you live in Colorado, the following statement applies to you:

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING:

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

If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:

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.

If you live in New Hampshire, the following statement applies to you:

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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Assurant Employee Benefits is the brand name for products underwritten or provided by Union Security Insurance Company.

If you live in New York the following statement applies to you:

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 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.

If you live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

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.

If you live in a state other than mentioned above, the following statement applies to you:

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.

INSURED'S IDENTIFYING INFORMATION

New claim

Claim already submitted

1. Full name of insured (<i>Please print.</i>)	2. Certificate number	3. Date of birth
4. Full address	5. Phone number	6. Social Security number
	7. <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced

EMPLOYMENT INFORMATION

9. Name and address of employer from whose policy you converted		10. Occupation
11. Are you currently employed?	12. Current occupation	13. Number of hours worked per week
14. Name and address of current employer		15. Phone number

DISABILITY INFORMATION

16. Nature of sickness or injury (*If due to accident, explain when, where and how it happened.*)

17. Date of first medical treatment for this condition If pregnancy, indicate conception and/or delivery date.	18. Date on which you were first unable to work
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19. Have you engaged in any work, part-time or otherwise, since your sickness or injury began? Yes No
(*If "Yes," please explain and give dates.*)

20. If you have recovered or returned to work, give date.	21. If still totally disabled, when do you expect to return to work?
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22. Names and addresses of all physicians who have been consulted because of this condition

Name	Address	Date of Consultation or Treatment

23. Have you been confined to a hospital for this disability? Yes No (*If "Yes," please complete.*)

Name of Hospital	Address	from	through

OTHER BENEFITS

24. Are you receiving, or are you entitled to receive, benefits from any of the following sources? **Each question must be answered.**

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| A. Salary, wages or commissions? | <input type="checkbox"/> | <input type="checkbox"/> | E. Workers' Compensation or similar legislation? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Retirement or pension plan? | <input type="checkbox"/> | <input type="checkbox"/> | F. Social Security or Railroad Retirement Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Veterans Administration | <input type="checkbox"/> | <input type="checkbox"/> | G. Any federal, state, provincial, municipal or other governmental agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any group insurance, health or welfare plan? | <input type="checkbox"/> | <input type="checkbox"/> | H. No-Fault or other automobile insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | I. Other sources? (<i>Give details below.</i>) | <input type="checkbox"/> | <input type="checkbox"/> |

For each question answered "Yes," please furnish the following information:

Name and Address of source	Group or Individual Basis	Policy or Claim Number (<i>if any</i>)	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid
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For Social Security, Workers' Compensation, and other similar benefits, please furnish a copy of the benefit award (*or denial letter, if applicable*).

AUTHORIZATION

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I understand** Union Security Insurance Company may discuss my limitations/restrictions with treating physicians and current or prospective employers as they relate to accommodations and possible return to work. I UNDERSTAND the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____ Date _____

HIPAA Authorization For Release of Protected Health Information



Insured/Member name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance company, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records, and strength/functional testing.

The sole purpose of this disclosure is for the adjudication of my claim for insurance benefits under the above-referenced Policy.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization to the address listed below:

The patient must pay any costs for completion of this form.

To the Attending Physician

Please read the following instructions before completing this form.

Do not separate the pages of this claim statement.

An authorization to release information can be found on pages 8 and 9.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the last page of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient _____	Date of birth _____	Social Security number _____
History	Patient's symptoms result from <i>(Check all that apply.)</i> : <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Pregnancy	
	If pregnancy, <i>(expected/actual delivery date)</i> _____ Type of delivery _____	
	Date symptoms first appeared _____ Patient's height _____ Weight _____	
	Name(s), address(es), specialty(ies) of other treating or referring physician(s) _____	
	First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____	
	Hospital name _____ Confinement dates _____ thru _____	
Diagnoses	Diagnoses with ICD9-CM codes: list in descending order of severity <i>(including any complications)</i> . Please go to the appropriate assessment section and elaborate. ICD9 _____	
	Subjective symptoms _____	
	Objective findings _____	
	Attach medical records which document the above diagnostics. <i>(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans)</i>	
Functional Assessment	In terms of an 8 hour day: <input type="checkbox"/> Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently. <input type="checkbox"/> Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently. <input type="checkbox"/> Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently. <input type="checkbox"/> Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting. <input type="checkbox"/> Class 5—Severe limitation; incapable of minimal activity or sedentary* work. <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <small>*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles</small>	
	Please fully describe the patient's capabilities: *With allowance for positional change. N =Never O =Occasionally (1/4–2 1/2 hours) F =Frequently (2 1/2–5 1/2 hours) C =Continuously (5 1/2–8 hours) _____ Standing* _____ Sitting* _____ Walking* _____ Driving* _____ Bending* _____ Data Entry* Lifting not more than _____ pounds _____(how often) Carry not more than _____ pounds _____(how often)	
	When did these capabilities begin? _____	
	Do you anticipate an increase in your patient's functional capabilities? If so, what date _____	

