Long Term Disability Claim Statement

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Employer Claim Statement—Part 1 *(Please print or type. If necessary, add separate sheet.)* New claim: ☐ Yes ☐ No

1. Name of employer	2. Policy/participation no.		3. Account no.
4. Full name of claimant	5. Social Security no.	6. Date employed	7. Effective date

8. Date last worked _____
Number of hours worked that day _____

9. Work schedule of claimant at time of disability:
_____ Days per week _____ Hours per day

10. Was claimant a member of a union at the time of disability? ☐ Yes ☐ No

11. Was plan effective when disability began? ☐ Yes ☐ No
If "No," please indicate date of termination _____

12. Was claimant covered under your prior LTD plan? ☐ Yes ☐ No
Effective date under **prior** plan _____
Termination date under **prior** plan _____

13. Does claimant have any other coverage(s) with Fortis Benefits?
☐ Yes ☐ No If "Yes," please advise of the type of coverage(s).

14. Has claimant returned to work? ☐ Yes ☐ No
If "Yes," on what date:
_____ With restrictions _____ Full capacity

15. Current work schedule of claimant?
_____ Day(s) per week _____ Hours per day

16. a. Have you and the claimant discussed reasonable accommodations which would allow a return to work? ☐ Yes ☐ No
b. Do you have an established return to work program? ☐ Yes ☐ No
If "Yes" to either, please explain.
c. What accommodations have you implemented?

17. Basic monthly earnings $_____

18. How is claimant paid? ☐ Hourly ☐ Salary + Commission ☐ Salaried ☐ Commission only
☐ Salary + Bonus ☐ Other _____

19. Does claimant contribute towards the cost of this LTD insurance? ☐ Yes ☐ No
If "Yes," what is the % paid by: _____ % Claimant _____ % Employer

20. Are claimant premium contributions made under Section 125 of the Internal Revenue Code? (i.e. a Cafeteria Plan paid with pre-tax dollars) ☐ Yes ☐ No

21. Is there any reason why FICA **should not** be withheld from the claimant's benefits? ☐ Yes ☐ No If "Yes," please explain.

22. Did this disability occur as a result of the claimant's employment? ☐ Yes ☐ No ☐ Currently disputed
If "Yes," or under dispute, please provide us with the policy no., name, address and phone no. of Workers' Compensation administrator.

23. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources?

☐ Salary continuance	Amount: _____ per _____	From _____ to _____
☐ Workers' Compensation	Weekly benefit _____	Effective date _____
☐ Retirement or pension	Benefit amount _____	Effective date _____
☐ Other _____	Lump sum distribution? ☐ Yes ☐ No	

24. Remarks

25.
Date _____ By _____
AUTHORIZED SIGNATURE/TITLE
Fax no. (_____) _____ Phone no. (_____) _____
E-mail address _____

Employer Claim Statement—Part 2
Physical/Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant's job.

Claimant's occupation _____

Signature/Title _____ Date _____

STAPLE YOUR OWN JOB DESCRIPTION HERE

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. of Hours	May Alternate Positions			
		At Will	15–30 Minutes	Hourly	Never
Sitting	_____	☐	☐	☐	☐
Standing	_____	☐	☐	☐	☐
Walking	_____	☐	☐	☐	☐
Driving	_____	☐	☐	☐	☐

2.

Claimant must	Never	Occasionally (1/4–2 1/2 hours)	Frequently (2 1/2–5 1/2 hours)	Continuously (5 1/2–8 hours)
A. Bend/Stoop	☐	☐	☐	☐
B. Climb	☐	☐	☐	☐
C. Reach above shoulder level	☐	☐	☐	☐
D. Kneel	☐	☐	☐	☐
E. Balance	☐	☐	☐	☐
F. Enter data/keystroke	☐	☐	☐	☐
G. Squat	☐	☐	☐	☐
H. Crawl	☐	☐	☐	☐
I. Crouch	☐	☐	☐	☐
J. Lift: Usual _____ lbs.	☐	☐	☐	☐
Max _____ lbs.	☐	☐	☐	☐
K. Carry Usual _____ lbs.	☐	☐	☐	☐
Max _____ lbs.	☐	☐	☐	☐
L. Push/Pull Usual _____ lbs.	☐	☐	☐	☐
Max _____ lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
   Right: ☐Yes ☐No Left: ☐Yes ☐No Both: ☐Yes ☐No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☐	☐	☐
B. Left	☐	☐	☐

5. Does job require:
   A. Working at unguarded heights? ☐Yes ☐No
   B. Exposure to marked changes in temperature and humidity or extremes thereof? ☐Yes ☐No
   C. Exposure to dust, fumes, gases, chemicals? ☐Yes ☐No

Stress/Non Physical

1. Percentage of time claimant spends answering customer complaints. _____ %
2. Percentage of claimant's work primarily judged on production. _____ %
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?
   ☐Yes ☐No _____ % of time
4. How many employees does this claimant supervise? _____
5. Is this claimant routinely subject to close supervision? ☐Yes ☐No
6. Percentage of time spent by the claimant working with his/her co-workers. _____ %
7. Percentage of claimant's time spent on: _____ % Prescheduled activities
   _____ % Random activities
8. Percentage of time claimant spends meeting deadlines set by others. _____ %
9. Percentage of responsibility the claimant has for the performance of his/her particular department. _____ %

DO NOT DETACH

Claimant Statement—Part 1 *(Please print or type.)*

Section I

1. Full name	2. Social Security no.	3. Date of birth
4. Address *(city, state, zip code)*		5. Home phone no. ( )
6. Sex: ☐ Male ☐ Female	7. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced	8. E-mail address
9. Names and birthdates of spouse and all dependent children under age 18.		10. Your occupation

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred.	2. Date first unable to work because of this disability.

3. Have you returned to work? ☐ Yes ☐ No If "Yes," on what date: _____ Part-time _____ Full-time

If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time

4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.

Name	Address	Dates of Consultation First Visit	Last Visit

5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.

Name of Hospital	Address	From	To

Section III

1. Check if you are receiving or entitled to receive benefits from any of the following sources:
   ☐ Salary, Wages or Commissions ☐ Retirement or Pension Plan ☐ Railroad Retirement Act
   ☐ State Disability ☐ Social Security Disability ☐ Other sources
   ☐ Workers' Compensation ☐ Social Security Retirement

   For each source marked above, please provide us with the following information:

Source	Amount of Income Amount	Frequency	Date Application Filed	Benefit Effective Date

Provide documentation of any source indicated above; i.e. award notices, denial notices or applications.

2. Do you have medical insurance? ☐ Yes ☐ No Policy no., name, address and phone no. of medical plan administrator.

   Please indicate the type of coverage provided *(Check all that apply.)*:
   ☐ Employer Group ☐ COBRA ☐ Conversion ☐ Individual ☐ Spouse ☐ Government ☐ Other *(Specify.)*_____

Section IV

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 Fortis Benefits Insurance Company, or its representative, any and all such information. I understand Fortis Benefits Insurance Company may discuss my limitations/restrictions with 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 Fortis Benefits 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.

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 _____

DO NOT DETACH

Claimant Statement—Part 2 *(Do not complete this section if you have returned to work, or if disability is for pregnancy.)*

Training, Education & Experience

1. What is your level of education?

   A. Have you received a high school diploma? ☐ Yes ☐ No
   Have you received the equivalent of a high school diploma (GED)? ☐ Yes ☐ No
   If yes to either, date earned _____ .
   If "No," please advise us of the last grade completed. _____ grade

   B. Have you attended college? ☐ Yes ☐ No
   ☐ Some college ☐ College graduate ☐ Post graduate

   Please specify: Major field of study _____
   Degree earned _____
   Date last attended _____

   C. Have you attended any trade schools or received any other special training? ☐ Yes ☐ No

   Please specify: Type of training _____
   Date last attended _____

   D. Do you have any computer skills? ☐ Yes ☐ No If "Yes," please list/describe.

2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.

3. What was your occupation when disability commenced and what were the usual duties of your occupation?

4. Which of the above job duties are you unable to perform?

5. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor?
   ☐ Yes ☐ No

6. Have you asked your employer to provide any accommodations which would allow you to return to work?
   ☐ Yes ☐ No If "Yes," what accommodations did you request and what was your employer's response?

7. What accommodations do you feel could be made by your employer to allow you to return to work?

8. Have you considered retraining? ☐ Yes ☐ No If "Yes," what vocational area(s) would interest you?

9. Please list any hobbies, outside interests or activities.

10. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation? ☐ Yes ☐ No

    If "Yes," what is the name, address and phone number of the counselor handling your case?

11. Have you contacted your state Division of Vocational Rehabilitation Department? ☐ Yes ☐ No

    If "Yes," what is the name, address and phone number of the counselor handling your case?

12. Would you like Fortis Benefits' Vocational Rehabilitation Department to contact you to discuss options available which may assist you in returning to gainful employment? ☐ Yes ☐ No

DO NOT DETACH

Attending Physician's Initial Statement of Disability

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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 in Part 1 of the Claimant's Statement.

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 reverse side 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 *(Check all that apply.)*: ☐ Employment ☐ Illness

☐ Auto accident *(state in which accident occurred)* _____ ☐ Other accident

☐ Pregnancy *(expected/actual delivery date)* ___/___/___ Type of delivery _____

Date symptoms first appeared ___/___/___ Patient's height _____ Weight _____

Name(s) and address(es) of other treating or referring physician(s)

Hospital name _____ Confinement dates ___/___/___ thru ___/___/___

Diagnoses

Diagnoses with ICD9-CM codes: list in descending order *(including any complications).* Please go to the appropriate assessment section and elaborate.

Subjective symptoms

Objective findings

Attach medical records which document the above diagnosis. *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.)*

Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No

Treatment

First visit for this condition ___/___/___ Most recent visit ___/___/___ Most recent comprehensive exam ___/___/___

Describe treatment program and give dates of any surgery, medications (dosages/administration routine), physical therapy or psychotherapy.

Frequency of treatment and/or symptoms: ☐ Weekly ☐ Monthly ☐ Other *(Specify.)* _____

Cardiac

Complete only if applicable.

Functional capacity (American Heart Association)

☐ Class 1 *(no limitation)* ☐ Class 2 *(slight limitation)* ☐ Class 3 *(marked limitation)* ☐ Class 4 *(complete limitation)*

Blood pressure (latest reading) ___/___ as of (date) ___/___/___

METS level _____ Date ___/___/___ Ejection fraction _____% Date ___/___/___

Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

If "Yes," please include dates. Start ___/___/___ End ___/___/___

DO NOT DETACH

Rehab

Is patient a candidate for vocational rehabilitation services? ☐ Yes *(Describe.)* ☐ No *(Explain.)*

Describe any job modifications that would aid your patient in performing his/her work tasks.

Has patient reached maximum medical improvement? ☐ Yes ☐ No If "No," when? ___/___/___ ☐ Unknown

Psychiatric Assessment

List the patient's DSM-IV Axes: I _____ II _____

II _____ IV _____

V _____ Date ___/___/___ Highest GAF in past year _____ Date ___/___/___

Please define stress as it applies to this patient.

What stress and problems in interpersonal relations has patient had on the job?

Please fully describe the patient's limitations.

When did these limitations apply?

Began ___/___/___ Anticipated reduction ___/___/___ Anticipated end date ___/___/___

Functional Assessment

☐ Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently.

☐ Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently.

☐ Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently.

☐ Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting.

☐ Class 5—Severe limitation; incapable of minimal activity or sedentary* work.

☐ Bed confined ☐ House confined

☐ Remarks

*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles

Please fully describe the patient's limitations.

When did these limitations apply?

Began ___/___/___ Anticipated reduction ___/___/___ Anticipated end date ___/___/___

Name

Physician's name _____ Degree _____ Specialty/Board certification _____

Address _____
STREET CITY STATE ZIP CODE

Telephone no. (_____) _____ Fax no. (_____) _____

Signature _____ Date ___/___/___ _____
DO NOT PRE-DATE PHYSICIAN'S EIN OR SSN

KC3283A (5/99)

DO NOT DETACH