Long Term Disability Claim Statement

Please read the following instructions carefully for proper completion of the attached Long Term Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion.

Do not separate the pages of this Claim Statement. Additional physician's statements may be obtained from your Regional Benefit Center or by copying the physician's statement included in this statement. Attach any additional physician's statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. If the claimant has returned to work or if the claim is for pregnancy, Part 2 of the Claimant's Statement does not need to be completed. After the Employer and Claimant Statements are fully completed, forward the entire statement to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

☞ **If you live in the state of Arizona, the following statement applies to you:**
For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

☞ **If you live in the state of Arkansas, 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:**
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.

☞ **If you live in the state of 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 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.

☞ **If you live in the state of Florida, the following statement applies to you:**
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.

☞ **If you live in the state of New Jersey, the following statement applies to you:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☞ **If you live in the state of Oregon, the following statement applies to you:**
Any person who, with 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 be guilty of insurance fraud.

☞ **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.

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

Listed below are Fortis' Regional Benefit Centers and corresponding addresses and toll-free numbers:
Fortis Benefits Insurance Company PO Box 40918 Indianapolis Indiana 46240-0918 • (800) 283-3636
Fortis Benefits Insurance Company PO Box 39844 Minneapolis Minnesota 55439-0844 • (800) 325-8385
Fortis Benefits Insurance Company (Home Office) PO Box 419876 Kansas City Missouri 64141-6876 • (800) 451-4531

Instructions for completion of the Employer's sections follow:

Employer Claim Statement—Part 1

Please indicate at the top of the form whether or not this is a new claim.

1.–6. Self-explanatory.

7. Effective date of the claimant's LTD coverage.

8. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.

9. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.

10. Self-explanatory.

11. Self-explanatory.

12. This question should be completed if your company had LTD coverage through a different carrier, immediately prior to your Fortis Benefits' coverage. If applicable, provide us with the claimant's effective and termination dates under the **prior plan**.

13. Any other coverages the claimant has with Fortis Benefits. (i.e., Life, Medical, Dental, etc.)

14.–15. If the claimant has returned to work, advise us of his/her **current** work schedule.

16. Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.

17.–18. The claimant's basic monthly earnings as of the determination date indicated in your LTD policy. For #18, if the claimant receives any bonuses, commissions or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.

19.–21. LTD benefits may be taxable. These questions are essential for us to make that determination. If question #21 is marked "Yes," please explain why FICA should not be withheld from claimant's benefits.

22. Self-explanatory.

23. For any source of income marked, please attach payroll records, award notices, denial notices or any other available documentation.

24. Self explanatory.

25. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

Employer Claim Statement—Part 2

Fully complete this section of the claim statement for **all** claims.

Please attach a copy of the employer's own description of the claimant's position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant's position. This section should be completed by someone who is familiar with the claimant's position; i.e. supervisor.

Physical Aspects

1. Self-explanatory.

2. Please tell us how often the claimant does each of the activities listed and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.
   Never = 0 hours; Occasionally = 1/2–2-1/2 hours; Frequently = 2-1/2–5-1/2 hours;
   Continuously = 5-1/2 hours or more

3.–5. Self-explanatory.

Stress/Non Physical Aspects

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.