Filing an Assurity Disability Income Claim

Disability income insurance provides a benefit when an insured person qualifies for disability as defined in the contract for a covered condition.

This document lists the forms and evidence required for submission of a claim for benefits. Additional information may be necessary to determine benefit eligibility and may require Assurity to order medical records. The required forms listed below can be accessed in the Customer Service Center on www.assurity.com or by contacting Assurity's Claims Department at **(800) 869-0355, Ext. 4484**.

Proof of Claim may be required within 12 months of the time of loss. Assurity administers many different plans of insurance. Your policy may not include all of the benefits detailed below. Please consult your contract for specific benefits, definitions, provisions, limitations and exclusions.

Disability Income	
	Information Needed/Required Proof for Claim
	1) Claimant Statement form #01-012-02255F – to be completed by the claimant; ***and*** 2) Attending Physician's Statement form #01-014-02255F – to be completed by your attending physician; ***and*** 3) Employer Statement form #01-013-02255F – to be completed by your employer; ***and*** 4) Confidential Information Authorization form – to be completed by claimant. Use the following list to find the appropriate authorization form number for the state in which the claimant resides: 75-500-05055 All states not listed below 48-500-05055 (AZ) 69-500-05055 (MN) 73-500-05055 (NC) 49-500-05055 (CA) 67-500-05055 (ME) 92-500-05055 (VA) 94-500-05055 (VT)
Riders listed below are available for some Assurity Disability Income products but are not necessarily a part of your contract. Please review your contract to verify any riders you may have selected.	
Additional Rider Benefits	
Potential Benefit	***Information Needed/Required Proof for Claim***
• Supplemental Disability Income Rider	The disability income claim forms listed above will be used to determine benefits for this rider. Additional information regarding social insurance coverage may be needed.
• Spouse Accident-only Disability Income Rider	If your spouse wishes to file a claim for Spouse Disability Income Rider benefits, the Disability Income claim forms listed above should be completed by your spouse, your spouse's physician and your spouse's employer. Your spouse must also sign the Authorization form.

If your contract includes benefits not described in this document or you have questions, please contact Assurity's Claims Department at **(800) 869-0355, Ext. 4484**.

Assurity® Life Insurance Company
PO Box 82533 • Lincoln, Nebraska 68501-2533

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(800) 869-0355, Ext. 4484 • Fax (800) 869-0368

Disability Claim Form
CLAIMANT STATEMENT

Please provide full and complete responses, indicating "none" where applicable. If more space is needed, please attach another sheet. Incomplete information may delay claim. If this claim is on a Spouse Accident Only Disability Rider ***(W215)***, check here ☐ .

First *Middle* *Last* Name	Policy no.
Street address *City* *State* *Zip code +4* Address	
Phone no. ( )	Social Security no.
MM/DD/YYYY Date of birth / /	☐ Male ☐ Female

Section I

1. ☐ Accident ☐ Illness 2. Date of accident or when illness began / / 3. Date last worked / /

4. Have you returned to work? ☐ Yes ☐ No If YES, when? _____

5. If injured, how and where did accident happen? *(If accident occurred at work, please provide details and/or accident report.)* _____

6. If illness, what is the nature? _____

7. Have you filed or will you file a worker's compensation claim? ☐ Yes ☐ No 8. Are premiums paid pre-tax? ☐ Yes ☐ No

Section II

1. Please provide the names and addresses of all physicians who have been consulted for any condition during the last five years. Please include dates of consultation. **All physicians treating claimant at the time of disability must complete Disability Claim Attending Physician's Statement.**

Physician's Name	*Complete Address* *City* *State* *Zip code +4*			
Phone no. ( )	*Fax no.* ( )	*First visit* / /	*Last visit* / /	*Physician's statement provided?* ☐ Yes ☐ No
Physician's Name	*Complete Address* *City* *State* *Zip code +4*			
Phone no. ( )	*Fax no.* ( )	*First visit* / /	*Last visit* / /	*Physician's statement provided?* ☐ Yes ☐ No

2. List the name and complete address of any hospital/clinic where you received medical treatment, consultation, care or services *(including diagnostic measures)* during the last five years. If additional space is needed, attach a separate sheet of paper.

Name of hospital/clinic	Complete address *(include city, state and zip code)*	Date(s) confined

3. List all prescription drugs taken for all reasons during the last five years. If additional space is needed, attach a separate sheet of paper.

Name of drug or medicine	Prescription no.	Pharmacy	First date used	Prescribing physician
			/ /	
			/ /	

4. Please provide the complete address of any pharmacy listed in question #3. If additional space is needed, attach a separate sheet of paper.

Name of pharmacy	Complete address *(include city, state and zip code)*	Phone/Fax no. *(include area code)*
		/
		/

Section III

1. Please provide the name(s) of all your disability carrier(s), their complete addresses and your policy number.

Name of disability carrier	Complete address *(include city, state and zip code)*	Phone no.	Policy/Med. record no.

Continue to page 2 of this form.

Policy/Certificate no.(s) _____ **Claimant's Name** _____

Section IV

Check if you are receiving or are eligible to receive benefits from any of the following sources:

☐ Salary, wages or commissions ☐ Retirement or pension plan ☐ Railroad Retirement act ☐ Workers' Compensation

☐ State Disability ☐ Social Security Disability ☐ Social Security Retirement ☐ Other sources

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

Source	Income benefit amount	Income benefit frequency	Date Application Filed	Benefit Effective Date
			/ /	/ /
			/ /	/ /
			/ /	/ /

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

Section V

Job title _____ Employer _____

Business Address _____ Phone no. ( ) _____

Earnings: ☐ Annual ☐ Monthly ☐ Hourly _____ Time employed in this occupation _____

Average number of hours worked per week _____ Time employed with this employer _____

Please list your normal duties below in order of importance. *(Attach second sheet if additional space is necessary.)*

Duty	Description	Percent of time spent

1. What percentage of your time is spent on: Heavy labor ____ % Light labor ____ % Administration ____ %

Travel ____ % Supervisory ____ % Clerical ____ %

2. What are the physical requirements of this job? _____

3. Do you have any other occupations? ☐ Yes ☐ No If YES, describe _____

4. Please list all job duties you are unable to perform due to your disability _____

FRAUD NOTICES

Unless specific state language is provided below for your state of residence, the following general fraud notice applies.

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Continue to page 3 of this form.

FRAUD NOTICES *(continued)*

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VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.

/ /		
Date (MM/DD/YYYY)	*Signature of claimant or legal representative*	*Printed name of person completing this form*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
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Disability Claim Form

ATTENDING PHYSICIAN'S STATEMENT

This form should be completed by all physicians who were treating the claimant during the time of disability. The patient is responsible for the completion of this form without expense to Assurity Life. Please print or type. If necessary add a separate sheet. Direct any questions to our claims department at the phone numbers shown above.

A. General Information

Patient's Name *(First , Middle, Last)*	Policy No.	Date of Birth *(MM/DD/YYYY)*
		/ /

Primary Diagnosis including ICD 9 or DSM Code

B. Complete this section for all conditions

Symptoms

Objective Findings

Are there secondary conditions contributing to the patient's inability to work? ☐ Yes ☐ No If YES, what are they?

When did symptoms first appear?	Date of patient's first visit *(MM/DD/YYYY)*	Date of the patient's last visit *(MM/DD/YYYY)*

How often do you treat/consult the patient?	Date you believe the patient was first unable to work *(MM/DD/YYYY)*

Was patient referred to you? *Referring physician's name* *Street address* *City* *State* *Zip+4*

☐ Yes ☐ No

Is the patient's condition work related? ☐ Yes ☐ No If YES, please explain:

Has the patient undergone surgery? ☐ Yes ☐ No If YES, please give date, procedure and result:

If no, do you expect surgery to be performed in the future? ☐ Yes ☐ No If YES, please give date and type of surgery:

What medications is the patient currently taking? *(Please list frequency and dosages.)*

Please indicate other types and frequencies of treatment:

Has the patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No If YES, please give details:

Have you referred the patient for other types of consultations? ☐ Yes ☐ No If YES, please give details:

Has the patient been hospital confined? ☐ Yes ☐ No If YES, complete the following:

Name of hospital *Street address* *City* *State* *Zip+4*

_____

MM/DD/YYYY *MM/DD/YYYY*

Confined: ____/____/____ through ____/____/____ Admission time _____ Dismissal time _____

Continue to page 2 of this form.

Policy/Certificate no.(s) _____ **Claimant's Name** _____

Indicate class of mental impairment (*if applicable):* ☐ Class 1–No limitation ☐ Class 2–Slight limitation ☐ Class 3–Moderate limitation ☐ Class 4–Marked limitation ☐ Class 5–Severe limitation

What is the patient's current DSM-IV-R diagnosis? ☐ Axis I _____ ☐ Axis II _____

☐ Axis III _____ ☐ Axis IV _____ ☐ Axis V _____

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

C. Complete this section for pregnancy

Date of the last menstrual period *MM/DD/YYYY* ___/___/___ First date of treatment *MM/DD/YYYY* ___/___/___ Expected due date *MM/DD/YYYY* ___/___/___

Date of delivery ___/___/___ *(MM/DD/YYYY)* This delivery is expected to be or was: ☐ Vaginal ☐ C-Section

Are there any present complications or anticipated difficulties in connection with:

a. Pregnancy ☐ Yes ☐ No b. Delivery ☐ Yes ☐ No c. Post partum ☐ Yes ☐ No

If YES, to any of the above, please specify in detail: _____

D. Information about the patient's inability to work. Complete this section for all conditions.

Briefly describe restrictions *(What the patient SHOULD NOT do)*:

Briefly describe limitations *(What the patient CANNOT do)*:

When was/is the patient able to return to work? Full-time ___/___/___ *(MM/DD/YYYY)* Part-time ___/___/___ *(MM/DD/YYYY)*

Does the patient's condition prevent being able to perform self care? ☐ Yes ☐ No If NO, please complete the following:

How soon do you expect fundamental changes in the patient's medical condition? ☐ 1-2 mos. ☐ 3-4 mos. ☐ 5-6 mos. ☐ 6 + mos.

Give details concerning expected improvement or deterioration:

Additional remarks:

E. Physician Information

Attending physician, please print

Physician's name _____ Degree _____

Phone no. (___) _____ Fax no. (___) _____ Specialty _____

Physician's address _____ *Street address* _____ *City* _____ *State* _____ *Zip+4*

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I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

Physician's Signature (no stamp)	*Date (MM/DD/YYYY)*	*TIN or Social Security No.*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(800) 869-0355, Ext. 4484 • Fax (800) 869-0368

Disability Claim Form
EMPLOYER STATEMENT

To be completed by employer. Please print or type. If necessary, add separate sheet.
Direct any questions to our claims department at the phone numbers and address shown above.

Employer name | Policy/Certificate no.(s)

Street address | *City* | *State* | *Zip code + 4*
Employer address

First | *Middle* | *Last*
Name of Employee | Date employed *MM/DD/YYYY* / /

Occupation | Employee's first payroll deduction *MM/DD/YYYY* / /

Attach written job description if available
Employee's primary job duties

1. Reason for stopping work: ☐ Dismissal/Termination ☐ Leave of Absence ☐ Illness ☐ Accident
☐ Resignation ☐ Retirement ☐ Layoff
If dismissed/terminated, date employment ceased ___/___/___ Date insurance terminated ___/___/___

2. If disabled, date last worked ___/___/___ Work schedule at that time: Days per week _____ Hours per day _____

3. If employee ceased work due to accident or illness, was the condition work related? ☐ 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.
_____
Has employee filed for Workers' Compensation benefits? ☐ Yes ☐ No

4. Was employee covered under your prior disability plan? ☐ Yes ☐ No Carrier name _____
Effective date ___/___/___ Termination date under **prior** plan ___/___/___ Prior coverage amount _____

5. Has the employee been offered Short-term Disability *(STD)* or Long-term Disability *(LTD)* coverage? ☐ Yes ☐ No
If YES, provide name of carrier _____

6. Has employee returned to work? ☐ Yes ☐ No ☐ Full-time return date ___/___/___
☐ Part-time return date ___/___/___ Hours per week _____
Will you provide "light duty" if employee is released with restrictions? ☐ Yes ☐ No
If employee has not returned to work, approximate return to work date ___/___/___

7. Annual salary $ _____ Hourly wage $ _____ Monthly commissions/overtime $ _____
Basic gross monthly earnings $ _____ Net monthly earnings $ _____

8. Premium contribution percentage: Employer _____ % Employee _____ %
If employee contributes toward the cost of disability coverage, please indicate ☐ **before** or ☐ **after** income is taxed.

IMPORTANT: Pages 2 and 3 must be completed and submitted with page 1.

Policy/Certificate no.(s) _____ **Claimant's Name** _____

9. To the best of your knowledge, is the employee receiving or eligible to receive benefits from any of the following sources?

☐ Salary continuance	Amount	$	per		From	/ /	to / /
☐ Short-term Disability *(STD)*	Amount	$	per		From	/ /	to / /
☐ Long-term Disability *(LTD)*	Amount	$	per		From	/ /	to / /
☐ Workers' Compensation	Amount	$	per		From	/ /	to / /
☐ Retirement or pension	Amount	$	per		From	/ /	to / /
☐ _____	Lump sum distribution? ☐ Yes ☐ No						

10. Remarks

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

NC RESIDENTS: 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 may also be subject to a substantial civil penalty where and to the extent allowed by state law.

NH RESIDENTS: 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.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM RESIDENTS: 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.

NY RESIDENTS: 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.

OH RESIDENTS: 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 is guilty of insurance fraud.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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.

VA RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.

Signed at _____ on _____

City *State* *Date (MM/DD/YYYY)*

_____ _____

Employer Authorized Representative's Signature *Representative's Printed Name and Title*

( ) / ( ) _____

Office Phone no. and Fax no. (please include area code) *Office E-mail Address*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • www.assurity.com

Confidential Information Authorization

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

_____ / / _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau),* or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(start and stop times)*, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be rediscloseed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(authorization to disclose HIV-related information is valid for 180 days from the date of the signature below)***, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ / / _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

_____
Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT