Claim for Short Term Disability Income Benefits

(See reverse side for instructions)

EMPLOYEE INFORMATION

1. Your Social Security Number
2. Your Last Name — First Name
3. Your Mailing Address — STREET — CITY — STATE — ZIP CODE
4. Clock / Badge Number
5. Plant Division / Location
6. Occupation
7. Your daytime telephone number
8. Date of birth (Mo. Day Year)
9. Date of accident or beginning of illness (Mo. Day Year)
10. Last date of work (Mo. Day Year)
11. Description of accident or illness
12. If accident, did it occur: ☐ In an Automobile? ☐ While at Work? ☐ Other
13. Have you, or will you file for Workers' Compensation Benefits? ☐ Yes ☐ No
14. Have you returned to work? If yes, date (Mo. Day Year)
15. Are you covered under another group insurance or government plan or automobile mandatory no-fault coverage which will also cover any of the disability loss of this claim? ☐ Yes ☐ No

If yes, give policy number, name and address of Insurance company.

POLICY NUMBER	NAME AND ADDRESS

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any dentist, physician, hospital, pharmacy, insurance company or organization to release any information regarding the medical, dental, mental treatment or disability benefits payable for this claim to the plan administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. I understand that this authorization or a photostat copy of the original shall be valid for one year from date of signature. I understand that data may be extracted and transmitted to the plan administrator for statistical audit and verification purposes. I also understand that I may request a copy of this authorization.

EMPLOYEE'S SIGNATURE	DATE

PHYSICIAN - COMPLETE THIS SECTION

1. Patient's Name: ____________________ Social Security #: ____________
2. Diagnosis: ____________________
3. Is this work related? ☐ Yes ☐ No
4. Describe current subjective symptoms: ____________________
5. What are your objective findings? ____________________
6. Please show dates of treatment: ____________________
   Date of surgery: ____________ Dates of hospitalization: ____________
   LMP: ____________ Date/Type of Delivery: ____________
7. What is current prognosis? ____________________
8. What limitations prevent patient from returning to work? ____________________
9. Because of these limitations, patient was totally disabled and prevented from performing all duties of his/her occupation:
   From | | | (Mo. Day Year) Through | | | (Mo. Day Year)
10. If still unable to work, when should patient be able to return to work? | | | (Mo. Day Year)

Remarks: ____________________

DATE	PHYSICIAN NAME (Please print)	DEGREE	SIGNATURE

TAX I.D. NUMBER / SOCIAL SECURITY #	TELEPHONE NUMBER
	( )

ADDRESS

INSTRUCTIONS FOR FILING A CLAIM

TO THE EMPLOYEE:

A. Complete the Employee Information and Authorization to Release Information of the form.
B. Have the Physician fill out the Physician section.
C. If you have any questions about a Disability claim, call our Disability Unit at: 800-985-3810 Toll Free anywhere in the U.S.
D. DO NOT use this form for Medical Expenses.
E. DO NOT use the Medical Form for Disability claims.
F. Return the FULLY completed form to:

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 5031
Wallingford, CT 06492-7531
Fax: 203-294-4298

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.