FORT DEARBORN LIFE
Insurance Company

Group Long-Term Disability Claim Form

Phone Number: 1 (800) 348-4510
Fax: (630) 824-5419

Return to Fort Dearborn Life at:
Attention Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

NOTE: All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

NOTICE OF CLAIM — Employer's Instructions

Approximately 6 to 8 weeks before the end of the elimination period:

A. Complete the Employer's Report of Claim in full;

B. Give claim form to claimant for completion; and

C. Request copy of awards from other sources of benefits: Social Security, Workers' Comp., retirement, state disability, and others.

When claimant returns the form to you:

A. Attach:
- Job description (detailed duties)
- Copy of enrollment card (only for contributory coverage, if available)
- Documentation of earnings if other than straight salary
- If Workers' Comp. claim filed, include copy of First Report of Accident and the decision

B. Return, together with all attachments, to Fort Dearborn Life at the address shown above.

APPLICATION FOR LTD BENEFITS — Employee's Instructions

A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Fort Dearborn Life or its representative to secure additional information if necessary to make a decision on your claim.

B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

A. Attach:
- A copy of your birth certificate (only if disability is indefinite and you are over age 50)
- A copy of Social Security and other income entitlement awards; and

B. Return to your employer.

ATTENDING PHYSICIAN'S STATEMENT (APS) — Physician's Instructions

As soon as the claimant gives you this form:

A. Complete the APS on the back of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.

B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

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. (Not enforceable in Oregon or Virginia.)

FORT DEARBORN LIFE
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Employer's Report Of Claim

To be Completed by Employer

CLAIMANT

1. Employee's Name (Last, First, Middle Init.)	2. Social Security No.	3. Date of Birth

4. Address	City	State	Zip Code

EMPLOYMENT

5. Insurance Class	6. Employee Date of Hire	7. Date employee became Insured for LTD	8. Date employee was actually last present at work

9. Occupation at time last worked (attach job description)

10. Work schedule at time last worked
No. of days per week ______ No. of hours per day ______

11. Reason for stopping:
☐ Sickness ☐ Granted LOA ☐ Laid Off
☐ Retired ☐ Dismissed ☐ Other
☐ Resigned ☐ Vacation

12. Has employee returned to work? ☐ Yes ☐ No
If Yes: ☐ Part-time ☐ Full-time
Date Date______

INCOME

13. How is employee paid?
☐ Straight Salary ☐ Hourly
☐ Salary & Commissions
☐ Commissions Only ☐ Salary & Bonus

14. Employee's Basic Monthly Earnings
$ ______ LTD Benefit ______
(If salary is based on less than 12 mos. – No. of mos. ______)

15. % of LTD premium contribution: By Employer ______ By Employee ______
Employee premiums for this coverage pre-taxed? ☐ Yes ☐ No

OTHER BENEFITS

16. Has insured received other disability payments since time last worked?

Salary Continuance:	Insured Short Term Disability	Other type: ______
☐ Yes Wkly. Amt. ______	☐ Yes Wkly. Amt. ______	☐ Yes Wkly. Amt. ______
Date benefits cease ______	Date benefits cease ______	Date benefits cease ______
☐ No	☐ No	☐ No

17. Did claim result from job activity?
☐ Yes (Explain)
☐ No

18. Has Workers' Compensation claim been filed?
☐ Yes (Enclose copy of 1st report of accident)
☐ No
☐ Pending
☐ Denied (Enclose copy of denial)

19. Workers' Comp. Weekly Amount:
$ ______

RETIREMENT

20. Is employee covered by employer sponsored retirement plan? ☐ Yes ☐ No

21. Does retirement plan contain a disability provision? ☐ Yes ☐ No

22. Is employee or will this employee be eligible for a disability or retirement pension? ☐ Yes ☐ No
If "Yes" type:
☐ Disability
☐ Retirement
☐ Other______
Monthly Amount $ ______
Commence Date of Benefits: ______
(enclose copy of summary plan description)

NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.

CERTIFICATION

23. Employer's Name (state association and name of policyholder, if other)	24. Telephone No. ( )	25. Group Policy No.

26. Address

27. Employer (Taxpayer) I.D. Number (EIN) ______ - ______
OR
28. Public Employer Social Security No. 69 ______ - ______

29. Name of person completing this form (please type or print)

30. Signature of Authorized Insurance Representative	Title	Date

FORT DEARBORN LIFE
Insurance Company

Employee's Claim Statement

To be Completed by Employee

CLAIMANT

1. Full Name (Last, First, Middle Init.)	2. Maiden Name	3. Alias Name	4. Social Security No.	5. Phone Number ( )

6. Address — City — State — Zip Code

7. Date of Birth (Mo. Day Year)	8. Height (ft. – in.)	9. Weight	10. Sex ☐ M ☐ F	11. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	12. Spouse's date of birth (Mo. Day Year) First Name	13. Is spouse employed? ☐ Yes ☐ No

14. Number of children (Under age 19)	15. List names and dates of birth of unmarried children who have not finished high school.

EMPLOYMENT

16. Employer's Name	17. Group Policy No.

18. Occupation (List the duties of your occupation at the time of disability)

19. Date of accident or date first noticed symptoms of illness: (Mo. Day Year)	20. I have been unable to work because of the disability since: (Mo. Day Year)	21. I returned to work on a part time basis on: (Mo. Day Year)	22. I returned to work on a full time basis on: (Mo. Day Year)

23. Is your accident or illness related to your occupation? ☐ Yes ☐ No

24. If "yes," explain

Have you or do you intend to file a Workers' Comp. Claim? ☐ Yes ☐ No

CLAIM HISTORY

25. Describe how and where accident occurred or describe the onset and nature of your illness.

26. Date you were first treated for your illness or injury. (Mo. Day Year)

27. Treated by:

Hospital: ______ (Name, Street Address, City, State, Zip Code)

Doctor: ______ (Name, Street Address, City, State, Zip Code)

28. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
If yes complete No. 27.

29. Treated by:

Hospital: ______ (Name, Street Address, City, State, Zip Code)

Doctor: ______ (Name, Street Address, City, State, Zip Code)

OTHER INCOME

30. Describe other income you are receiving:

Yes	No	Type	Amount	Date Began	Date Term.
☐	☐	Social Security (disability or retirement)	$______	______	______
☐	☐	State disability	$______	______	______
☐	☐	Retirement (normal, early or disability)	$______	______	______
☐	☐	Workers' Compensation	$______	______	______
☐	☐	Group disability benefits	$______	______	______
☐	☐	Other (describe) ______	$______	______	______

31. Have you applied, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type ______ Date application filed ______

Type ______ Date application filed ______

32. If your request for benefits is approved, do you want us to withhold amounts from each benefit for Federal Income Tax purposes? ☐ Yes ☐ No If yes, please complete and attach IRS Form W4S.

AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Fort Dearborn Life Insurance Company's (FDL) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim.
This authorization expires on the date I receive notice of FDL's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation. Information disclosed may be redisclosed and no longer protected by federal privacy laws. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from FDL. **If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny my claim.**

Signature of Employee ______ Date ______

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Insurance Company

Attending Physicians Statement

Name of patient | Date of Birth | * Please submit bill for records with this claim.

HISTORY

(a) When did symptoms first appear or accident happen?

(b) Date patient ceased work because of disability?

(c) Has patient ever had same or similar condition?
☐ Yes If "Yes" state when and describe
☐ No

(d) Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☐ No ☐ Unknown

(e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (Including complications) Please submit all office notes in regard to this condition*

(b) Subjective symptoms

(c) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings?)

TREATMENT

(a) Date of first visit

(b) Date of last visit

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify)

(d) Nature of treatment (Including surgery and medications prescribed, if any)

PROGRESS

(a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No Confined from ____________ through ____________
If, yes, give Name and Address of Hospital:

CARDIAC

(a) Functional capacity (American Heart Ass'n.)
☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood Pressure (last visit)
____________ systolic/diastolic

IMPAIRMENT

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles).
☐ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
☐ Class 2 - Medium manual activity* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)
Remarks:

(b) Mental Impairments (If applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?
☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
Remarks:

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No

(b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future?
☐ 1 Mo. ☐ 1-3 Mo. ☐ 3-6 Mos. ☐ Never. Applies To: ☐ Patient's job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

(c) When could trial employment commence? Date ____________ PATIENT'S JOB ☐ Full-time ☐ Part-time Date ____________ ANY OTHER WORK ☐ Full-time ☐ Part-time

REMARKS

(Limitations, Therapy, etc.)

Name (Attending Physician) *Print*	Degree	Telephone ( ) Fax #: ( )

Street Address	City or Town	State	Zip Code

Signature	Date

The laws of some states require us to furnish you with the following notice:

Arizona & New Jersey - Claims

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

Arkansas & Massachusetts

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.

Colorado

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.

Delaware, Idaho & Oklahoma

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

District of Columbia, Virginia & Washington

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.

Florida

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.

Louisiana & New Mexico

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.

New Hampshire

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."

New Jersey - Applications

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

Texas

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.

Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurnace company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States

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. (not enforceable in OR)