LeadersLife INSURANCE COMPANY

Disability Insurance Claim Form
Insured's Statement

Please Answer all questions fully as this will help expedite the evaluation of your claim. Instructions: Complete the claim form, sign and date the authorization for Release of Information and the Fraud Statement. Have your Physician complete the Physician's statement and your Employer complete the Employer's statement and return all documents to the claim administrator through one of the avenues displayed below.

POLICY/CERTIFICATE HOLDER INFORMATION

Full Name of Policy/Certificate Holder _____ Date of Birth _____

Policy Number _____ Social Security Number _____

Phone Number _____ Email Address _____

Street Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

CLAIMANT INFORMATION (if different from above)

Full Name of Claimant _____ Date of Birth _____

Relationship of Claimant to Policy/Certificate Holder _____

Employer _____ Occupation _____

DISABILITY

What is your Diagnosis/Condition:_____

Is your disability the result of an Illness or Injury? _____ Date of Injury/Illness _____

If injured, how, when, and where did injury occur? _____

Date first treated _____ Last Day Worked _____

*If filing for disability within the first two years of the policy, medical records may be requested.

Is your condition work related? ☐Yes ☐No Were you hospitalized as a result of condition? ☐Yes ☐No

If hospitalized, name of hospital _____ City/State_____

Have you ever had the same or similar condition? ☐Yes ☐No (If yes, when: _____

Have you returned to work? ☐Yes ☐No If yes, date returned _____ No. Hrs Working _____

Are you entitled to benefits from any sick leave or formal salary continuation plan as a result of this disability? ☐Yes ☐No

If Yes, please provide type of benefit and amount:_____

I represent that all statements and answers in this claim form are complete, true and correctly recorded to the best of my knowledge and belief and that I have appropriate knowledge to answer the questions for my spouse.

Signature of Policy/Certificate Holder _____ Date _____

Authorization for Release of Information HIPAA Compliant

Full Name of Insured/Claimant Name _____ Date of Birth _____ Social Security Number _____

I hereby authorize all the people and organizations listed below to give Leaders Life Insurance Company and its authorized representatives, including agents and insurance support organization, (collectively, the "Recipient"), the following information:

- any and all information documents, treatment notes (including psychotherapy notes), consultation notes, and reports of diagnostic procedures relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries ; hospital confinements for physical and mental conditions,; use of prescription drugs, use of drugs or alcohol; and communicable diseases including HIV or AIDS.
- any and all information relating to my occupations, my employment, or my activities.

I hereby authorized each of the following entities to provide the information outlined above:

- any physician or medical practitioner, hospital, clinic or other health care facility,
- any pharmacy or pharmacy benefit manager,
- any insurance or reinsurance company (including, but not limited to, the Recipient),
- any consumer reporting agency or insurance support organization,
- my employer, group policyholder, or benefit plan administrator,
- the Medical Information Bureau (MIB), and
- any other person or business.

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for coverage and/or benefits under an insurance policy; and
- detect insurance fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance company listed above is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Leaders Life Insurance Company's Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or where law allows the Recipient to contest a claim under the policy or to contest the policy itself , by sending a written request to: Leaders Life Insurance Company, P.O. Box 86, Bloomfield, CT 06002. I understand that my revocation of this authorization will not affect prior uses and disclosure of my health information by the Recipient for purposes of claim administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipient may not be able to obtain the information necessary to consider my claim for benefits.

I further understand an investigative consumer report may be requested concerning factors affecting my eligibility for insurance benefits. The factors which may be investigated include my activities, personal characteristics, mode of living, and health history. The report may be obtained through personal interviews with my friends, neighbors, and associates. I have a right to submit a written request to Leaders Life for a complete and accurate disclosure of the nature and scope of any such report.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Name of Insured/Claimant (print) _____ Date _____

Signature of Insured/Claimant/Guardian/Representative _____ Description of Authority of Personal Representative (if applicable) _____

DMS P.O. BOX 15309 SPRINGFIELD, MA 01115-5309 Fax (860) 761-1801 (888) 342-7979 DLHCustomerService@us.davies-group.com

LeadersLife INSURANCE COMPANY

Fraud Statement

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of a crime and may be subject to fines and imprisonment.

Applicable to **AL** residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Applicable to **AR** and **LA** 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 fines and confinement in prison.

Applicable to **FL** residents: 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.

Applicable to **KS** residents: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of insurance fraud as determined by a court of law.

Applicable to **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.

Applicable to **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.

Applicable to **TX** residents: Any person who knowingly presents a false of fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed at (city) _____ State_____this _____ Day of _____,20_____

_____ Signature of Claimant

_____ Signature of Owner(if other than Claimant)

Social Security Number of Claimant _____

DMS P.O. BOX 15309 SPRINGFIELD, MA 01115-5309 Fax (860) 761-1801 (888) 342-7979 DLHCustomerService@us.davies-group.com

Attending Physician's Statement

LeadersLife INSURANCE COMPANY

To be completed by the physician without expense to the company.

PATIENT'S INFORMATION

Full Name of Patient _____ Date of Birth _____

PHYSICIAN'S INFORMATION

Full Name of Physician _____ Degree/Specialty _____

Phone Number _____ Fax Number _____

Street Address _____

City _____ State _____ Zip _____

PATIENT HEALTH HISTORY - ☐ Initial Claim-Complete Section I ☐ Ongoing Claim-Complete Section II only

SECTION I

What is the Patient's Diagnosis/Condition/ICD Code: _____

Symptoms First Occurred _____ Date First Treated: _____ Date Last Seen: _____

Date of Next Visit: _____ Is Patient being seen by another physician for this condition? ☐ Yes ☐ No

If Yes, please provide Name of the Physician _____ City/State _____

Is the Patient Totally Disabled at this time due to this diagnosis? ☐ Yes ☐ No

Was disability the result of an Illness or Injury? ☐ Yes ☐ No

Date of Injury/Illness: _____ If injured, how, when, and where did injury occur? _____

Is Patient's condition work related? ☐ Yes ☐ No Was Patient hospitalized as a result of condition? ☐ Yes ☐ No

If hospitalized, name of hospital _____ City/State _____

If pregnancy, Date of Delivery _____ ☐ Vaginal Delivery or ☐ Cesarean Patient released to return to work? ☐ Yes ☐ No

If Yes, Date Released: _____ If No, date expected to return _____ or next appointment date _____

SECTION II (COMPLETE FOR CONTINUING DISABILITY ONLY)

Date Last Seen: _____ Has Patient returned to work? ☐ Yes ☐ No If yes, date released _____

If no, date expected to return _____ or next appointment date _____

I HEREBY CERTIFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Physician _____ Date _____

LeadersLife INSURANCE COMPANY

Employer's Statement

EMPLOYER INFORMATION

Full Name of Employer _____ Contact Name _____

Phone Number _____ Email Address _____

Street Address _____

City _____ State _____ Zip _____

EMPLOYEE (POLICY/CERTIFICATE HOLDER) INFORMATION

Full Name of Employee, Policy or Certificate Holder _____ Date of Birth _____

Certificate No. _____ Social Security Number _____

CLAIMANT INFORMATION

Full Name of Claimant _____ Date of Birth _____

Relationship of Claimant to Policy/Certificate Holder _____

OCCUPATIONAL/DISABILITY INFORMATION ☐ Initial Claim-Complete Section I ☐ Ongoing Claim-Complete Section II

SECTION I

Occupation_____ Pre-Disability Average Hours Worked _____

Date of Hire _____ Disability Due to Work Related Incident? ☐ Yes ☐ No Date Last Worked _____

Current Salary Gross $ _____ Average Salary Past Two Years Gross $_____

Employee eligible for formal Salary Continuation Benefit?
☐ Yes ☐ No If yes, amount $_____
Benefits begin _____ Benefits end _____

Employee eligible for Sick Leave?
☐ Yes ☐ No If yes, amount $_____
Benefits begin _____Benefits end _____

Did Employer pay a portion of the disability coverage premium? ☐ Yes ☐ No If yes, what percentage _____%

Has the Employee Returned to Work? ☐ Yes ☐ No

If Yes, Date Returned _____ Hours working per week _____ Employee able to perform job duties? ☐ Yes ☐ No

If No, what is the expected date to return to work _____

SECTION II

Has the Employee Returned to Work? ☐ Yes ☐ No

If Yes, Date Returned _____ Hours working per week _____ Employee able to perform job duties? ☐ Yes ☐ No

If No, what is the expected date to return to work _____

WHEN EMPLOYEE RETURNS TO WORK, PLEASE NOTIFY LEADERS LIFE IMMEDIATELY.

Employer Signature _____ Title _____ Date _____