ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(800) 869-0355, Ext. 4484 • Fax (402) 437-4592

Initial 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 Address	*City*	*State* / *Zip code +4*
Phone no. ( )	Social Security no.	Date of birth *MM/DD/YYYY* / /	☐ 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.

Claimant pg. 2

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 _____

Home Office Use Only Certificate form no. _____ Type _____

Prem. Paid-to-Date _____ Claimant's Cert. Effective Date _____ Prior Coverage? ☐ Yes ☐ No

Effective Date _____ Prior Benefit Amt. _____ Prior Company Name _____

FRAUD NOTICES

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I hereby acknowledge that I have read the applicable state fraud information 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
(402) 476-6500 • (800) 276-7619

Claimant

Confidential Information AUTHORIZATION

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

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

Applicant/Insured/Claimant Child(ren)

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

I, on behalf of myself or the person named above *(Individual)*, authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company *(Assurity)*, its reinsurers and/or consumer reporting agencies and their authorized representatives *(provided, however, consumer reporting agencies may not collect information under this authorization from the MIB)*:

- 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 ***(Except information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.)***. **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- 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 session 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.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in 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 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, the Medical Information Bureau *(MIB)*, 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 re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(Except for residents of Arizona, 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)

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Attending Physician's Statement
DISABILITY CLAIM

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.

A. General Information

Patient's Name	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 code + 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 code + 4*

Confined: *MM/DD/YYYY* / / through *MM/DD/YYYY* / / Admission time _____ Dismissal time _____

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

Continue to page 2 of this form.

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. Signature

Attending physician, please print

Physician's name | Degree

Phone no. ( ) | Fax no. ( ) | Specialty

Physician's address — *Street Address* / *City* / *State* / *Zip Code + 4*

I hereby acknowledge that I have read the applicable state fraud information below.
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.*

Direct any questions to our claims department at the phone numbers shown above.

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Disability Claim Form
EMPLOYER STATEMENT

To be completed by employer. Please print or type. If necessary, add separate sheet.

Employer name _____ Policy/Certificate no.(s) _____

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

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

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

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

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.

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

IMPORTANT: Page 2 must be completed and submitted with page 1.
Direct any questions to our claims department at the phone numbers shown above.

employer pg. 2

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FRAUD NOTICE

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

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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)*

_____ _____
Authorized signature *Printed name and title of official representative*

( ) _____ / ( ) _____ _____
Phone no. and Fax no. (please include area code) *E-mail address*