CLAIM FOR ASSOCIATION DISABILITY BENEFITS

Unimerica Insurance Company
PO Box 15256
Portland, ME 04112-5256
Claim Questions 800.539.0038 Fax 888.505.8550

This form should be used for the following types of claims only:

- Business Overhead Expense (BOE)
- Disability Income (DI)
- Long Term Disability (LTD)
- Short Term Disability (STD)

This form must be completed by the Attending Physician, the Employee, and the Employer and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please keep a copy of this form and any attachments for your records.

The claimant is responsible for completion of all portions of this form without expense to Unimerica Insurance Company.

INSTRUCTIONS:

A. **Attending Physician's Statement:** This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form. To avoid delay in evaluating your claim, advise your physician(s) to attach copies of medical records and test results to the Attending Physician's Statement.

B. **Claimant's Statement:** This section must be completed by you, the employee.

C. **Employment Statement**: The employer must complete this form.

D. **Authorization:** This form must be signed and dated by you, the employee. Please provide a copy of the signed and dated form to your attending physician.

E. **TRANSMIT** completed forms and attachments to:

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Please enclose any additional information that you feel will assist us in evaluating this claim. Note: You may be required to provide earnings, tax, profits and loss, expense, or other financial information to support your claim

ASSOCIATION DISABILITY CLAIM

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A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number
Employer Name		Employer Telephone Number	

Conditions

1. Diagnosis - Please include the primary diagnosis and list any secondary conditions, including ICD10 and/or DSMIV:

2. Date First Unable to Work	Date Hospitalized

3. Has patient been released to work in his/her own occupation? ☐Yes ☐ No In any occupation? ☐Yes ☐ No
If not, when should the patient be able to return to work? (Please provide date) Full Time _____ Part Time _____

4. Is this disability related to the patient's employment? ☐Yes ☐ No ☐ Unknown

5. Is this disability due to a normal pregnancy or complications of pregnancy? ☐Yes ☐ No (if yes, please circle) Normal Complications

If there are or have been complications pre-natal, post-natal, or at time of delivery, please describe:

Expected Delivery Date:	If Delivered, Actual Delivery Date:	Type of Delivery ☐Vaginal ☐C-Section

6. Date of first visit for this illness or injury

7. Nature of treatment (including surgery and medications prescribed)	Name of Surgical Procedure	Date of Surgery

8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)

LIMITATIONS (What the patient cannot do)

Date restrictions and limitations began:

The above statements are true and complete to the best of my knowledge and belief.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Print or Type Name	Degree		Medical Specialty
Street Address			Telephone Number
City	State	Zip	Fax
Signature of Physician			Date
SSN or Employers ID	Are you the physician to this patient? ☐Yes ☐ No If yes, what is the relationship?		

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B. CLAIMANT'S STATEMENT (PLEASE PRINT)

1. Claimant's Name (as printed on your Social Security Card)	Telephone Number	Date of Birth	☐Male ☐Female	Social Security Number

Home Address (Street, City, State, ZIP)

2. Employer Name	Phone Number	Occupation

Employer Address

3. Date Last Worked (Please include number of hours worked on that day)

Have you returned to work? (Please circle) Yes No	Date of Return/Expected Return	Job Status (please circle) Part Time Full Time	Hours per week

If you have returned to work, please list your occupational duties and number of hours per week spent at that duty

How does your injury or sickness affect your ability to do your occupational duties?

4. Marital Status ☐Single ☐Married ☐Widowed ☐Divorced	Spouse's name	Spouse's Date of Birth	Is Spouse employed ☐Yes ☐ No

List your dependent children who are under age 25 (Name, Date of Birth):

5. Is this disability due to ☐Motor Vehicle Accident ☐Other Accident ☐Sickness ☐Work-related Injury/Sickness ☐Pregnancy

For any accident related claim, describe the injury (what, how, where, when):

6. Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.
If you have been approved or denied for any of these benefits, please send a copy of award or denial notification.

Social Security/Retirement ☐Yes ☐No	Social Security/Disability ☐Yes ☐No	Canada Pension Plan ☐Yes ☐ No	State Disability ☐Yes ☐ No
Worker's Compensation ☐Yes ☐No	Pension/Retirement ☐Yes ☐No	Pension/Disability ☐Yes ☐No	Unemployment ☐Yes ☐ No
No-Fault Insurance ☐Yes ☐No	Short Term Disability ☐Yes ☐No - Ins. Co. Name and Policy #		
Other (Include Individual Disability or Group Disability Benefits) ☐Yes ☐No - Ins. Co. Name and Policy #			

7. For Fully-Insured Plans - If your request for benefits is approved, do you want Federal Income Tax withheld from your check? ☐Yes ☐No
If yes, please indicate dollar amount $ _____(Note: Minimum withholding is $88.00 per month) Do you want State Income Tax withheld from your check? ☐Yes ☐No If yes, please indicate dollar amount $ _____(Note: The amount indicated must be a whole dollar increment)

For Self-Insured Plans - Attach a copy of your completed W-4 for accurate calculation of Federal and State income taxes. If not provided, we will withhold 25% of your benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Signature_____ Date _____

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C. EMPLOYMENT STATEMENT (PLEASE PRINT)

Type of Coverage (CIRCLE ALL THAT APPLY) Disability Income; Business Overhead Expense; Long Term Disability; Short Term Disability

1. Employer Name	Employer Phone Number
Employer Address (Street. City, State, ZIP)	
2. Claimant's Name	
Claimant's Address (Street, City, State, ZIP)	

Social Security Number	Date of Hire	Effective Date of this Insurance	Date Last Worked

3. Does this claimant work in more than one office or location? If yes, please provide other addresses and phone numbers:

Has the claimant's employment been terminated? ☐Yes ☐ No	If yes, please provide termination date:	
4. Has claimant returned to work? ☐Yes ☐ No	If yes, date	☐ Full Time ☐ Part Time Hours Per Week _____
Does this claimant have Group LTD or STD? (If Yes, Please Circle Type) LTD STD	Carrier name	Policy Number(s)

5. Job Title/Major Job Duties **(Please attach a copy of claimant's job description)**

6. How was the disability premium paid for the plan year in which the disability occurred?
Percentage paid by Employer _____% Was the premium amount paid by the employer included in the employee's W-2? ☐Yes ☐ No
Percentage paid by Employee_____% ☐Pre-tax ☐Post-tax

7. Year to Date Earnings $

8. Financial Documentation (please refer to your contract for your Earnings definition and attach the appropriate documentation).
Salary Only/Current Earnings definition: Attach copy of payroll records or pay stubs for 2 periods just prior to disability.
Bonus/Commissions Included: Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.
Other Earnings definitions: Attach referenced document per Earnings definition (W-2, K-1s, Schedule Cs, teacher's contract, etc.).

9. Does the claimant have an ownership interest in this business? ☐ Yes ☐ NO If yes, what is the % of ownership? _____%
Type of business entity? ☐Regular Corporation ☐ S Corporation ☐Partnership ☐Sole Proprietorship

10.Is claimant eligible for	Yes No	
Health Insurance	☐ ☐	If yes, name and address of Carrier
Life Insurance	☐ ☐	If yes, please provide the name and address of the carrier and the amount of coverage

11. Information about your pension plan (**Please send copy of Plan Summary**)

Do you have a pension plan? ☐Yes ☐ No	If yes, what type? ☐Defined benefit ☐Defined contribution ☐ 401(k)/403(b) ☐Profit Sharing ☐Other (specify)_____	
Is claimant eligible for your pension plan? ☐Yes ☐ No	If eligible, does the claimant participate? ☐Yes ☐ No	What % does claimant contribute? _____%

If the claimant is participating, when is he or she eligible for benefits under the plan?

The above statements are true and complete to the best of my knowledge and belief.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Name of Person Completing Form	Telephone Number
Title of Person Completing Form	Fax Number
Signature	Date Signed

DISCLOSURE AUTHORIZATION

TO BE COMPLETED BY CLAIMANT

Name (Please Print) _____

I AUTHORIZE any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give Unimerica Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE any financial institution, accountant, tax preparer, insurance company or re-insurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or over insurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or Claimant's Authorized Representative:_____

Date: _____ Relationship, if other than Claimant: _____

RETURN TO:

Unimerica Insurance Company
PO Box 15256 Portland ME 04112-15256
Tel 800 539 0038 Fax 888 505 8550

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Alabama:

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.

For claimants in Alaska:

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For claimants in Arizona:

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For claimants in California:

UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For claimants in 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.

For claimants in Connecticut:

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Delaware:

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For claimants in District of Columbia:

WARNING: 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.

For claimants in 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

For claimants in Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Idaho:

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For claimants in Indiana:

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For claimants in Kansas:

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 may be guilty of fraud as determined by a court of law.

For claimants in Kentucky:

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

For claimants in Maine:

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

For claimants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Minnesota:

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

For claimants in 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.

For claimants in New Jersey:

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

For claimants in 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 penalties.

For claimants in Ohio:

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.

For claimants in Oklahoma:

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

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Oregon:

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Pennsylvania:

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.

For claimants in Tennessee and Washington:

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

For claimants in 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.

For claimants in Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:

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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:

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.