

**Statement of Claim
For Group Insurance Benefits(LTD)
Long Term Disability**



600 NORTHERN BLVD
GREAT NECK, NY 11021-5202

EMPLOYER'S CERTIFICATION

EMPLOYER'S NAME		EMPLOYER'S ADDRESS (Street, City, State, Zip Code)		POLICY NUMBER
EMPLOYEE'S NAME (Last, First, Middle Initial)		DATE EMPLOYED	DATE EMPLOYEE INSURED	EMPLOYEE'S SOC. SEC. NO.
EMPLOYEE <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED	DATE LAST WORKED	DATE OF RETURN (If back to work)	IF COVERAGE IS TERMINATED, GIVE DATE	EMPLOYEE'S BASIC WAGES OR SALARY (If claim is for Weekly Disability) \$ <input type="checkbox"/> Annual <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly
JOB DESCRIPTION				
SIGNATURE AND TITLE OF AUTHORIZED PERSON				DATE

EMPLOYEE'S STATEMENT (Complete for all claims)

EMPLOYEE'S NAME (Last, First, Middle Initial)		EMPLOYEE'S ADDRESS	
EMPLOYEE'S DATE OF BIRTH		EMPLOYEE'S SOCIAL SECURITY NO.	
<input type="checkbox"/> MALE <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		Street _____ City _____ State _____ Zip _____ Telephone No. Area Code (_____) _____	
HAVE YOU PREVIOUSLY BEEN TREATED FOR THIS OR A RELATED MEDICAL PROBLEM ? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, STATE WHEN AND GIVE NAME(S) AND ADDRESS(ES) OF DOCTOR(S) OR HOSPITAL(S)			
WAS THIS ILLNESS OR INJURY SUSTAINED IN CONNECTION WITH ANY EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		NATURE OF ILLNESS OR INJURY	
RESULT OF AUTOMOBILE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF FIRST TREATMENT	
IF ACCIDENT INVOLVED, GIVE DATE, HOW, AND WHERE ACCIDENT OCCURRED			

COMPLETE THE FOLLOWING

ARE YOU RECEIVING, OR ARE YOU ENTITLED TO RECEIVE, BENEFITS FROM ANY OF THE FOLLOWING SOURCES?
EACH QUESTION MUST BE ANSWERED.

A. SALARY WAGES OR COMMISSIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	E. VETERANS ADMINISTRATION	<input type="checkbox"/> YES <input type="checkbox"/> NO
B. ANY GROUP INSURANCE, HEALTH OR WELFARE PLAN	<input type="checkbox"/> YES <input type="checkbox"/> NO	F. RETIREMENT OR PENSION PLAN	<input type="checkbox"/> YES <input type="checkbox"/> NO
C. WORKMEN'S COMPENSATION OR SIMILAR LEGISLATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	G. OTHER SOURCES (give details below)	<input type="checkbox"/> YES <input type="checkbox"/> NO
D. SOCIAL SECURITY OR RAILROAD RETIREMENT ACT	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	

FOR EACH QUESTION ANSWERED "YES " PLEASE FURNISH THE FOLLOWING INFORMATION:

NAME AND ADDRESS OF SOURCE	GROUP OR INDIVIDUAL BASIS	POLICY OR CLAIM NUMBER, IF ANY	EXACT DATE BENEFITS COMMENCED OR WILL COMMENCE	LENGTH OF BENEFIT PERIOD	AMOUNT OF EACH PERIODIC BENEFIT	TOTAL AMOUNT OF BENEFITS PAID

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I hereby authorize any Insurance Company, Prepayment Organization, Employer or provider of medical services to release all information with respect to myself or my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information given by me in support of this claims true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ EMPLOYEE SIGNATURE _____

**Health Insurance
Claim Form
TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

PATIENT & INSURED (SUBSCRIBER) INFORMATION					
PATIENT'S NAME (First name, Middle, Initial, Last name)			WAS CONDITION RELATED TO : A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> <input type="checkbox"/> NO B. AN AUTO ACCIDENT YES <input type="checkbox"/> <input type="checkbox"/> NO		
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the Release of any Medical Information Necessary to process this Claim.					
SIGNED _____		DATE _____			
PHYSICIAN OR SUPPLIER INFORMATION					
DATE FIRST CONSULTED YOU FOR THIS CONDITION			HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ? YES <input type="checkbox"/> <input type="checkbox"/> NO		
DATE PATIENT ABLE TO RETURN TO WORK		DATES OF TOTAL DISABILITY FROM _____ THROUGH _____			
FOR SERVICES RELATED TO HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____					
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 1. _____ 2. _____ 3. _____ 4. _____					
DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		DIAGNOSIS (ICDA Code No.)	
		PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		
1. Type of treatment being rendered _____ _____ 2. Result of any diagnostic tests performed _____ _____ 3. Frequency of patient visits to your office _____ 4. Prognosis for the claimant returning to gainful employment _____ _____ 5. Estimated duration of total disability _____ 6. Dates of treatment _____ 7. Restrictions from claimant's present occupation _____ _____					
SIGNATURE OF PHYSICIAN OR SUPPLIER			PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
SIGNED _____		DATE _____	I.D.NO. _____		

* PLACE OF SERVICE CODES
 1-(IH)- INPATIENT HOSPITAL 4(H) - PATIENT HOME 7-(NH) - NURSING HOME 0-(OL)- OTHER LOCATIONS
 2-(OH)- OUTPATIENT HOSPITAL 5- DAYCARE FACILITY 8-(SNF)- SKILLED NURSING FACILITY A- (IL) INDEPENDENT LABORATORY
 3-(O) DOCTOR'S OFFICE 6- NIGHT CARE FACILITY(PHY) 9- AMBULANCE B- OTHER MEDICAL/SURGICAL FACILITY