Chubb Workplace Benefits
A business unit of Combined Insurance
Company of America, a Chubb Company
Administrative Office
One Integrity Parkway
Cleveland, OH 44143
Telephone: (855) 241-9891

CHUBB

LBT Statement of Disability

Claimant's Information

Insured's Name | Policy Number | Date of Birth (Mo / Day / Year)

Insured's Address (Street and No.) | City | State | Zip

Employer's Name

Employer's Address (Street and No.) | City | State | Zip

Disability Benefits In Force - Other Companies (If none, state none.)
COMPANY | DISABILITY WAIVER | DATE ISSUED | DISABILITY INCOME | DATE ISSUED

What is the diagnosis of the insured's medical condition? | Date first diagnosed? (Mo / Day / Year) | Date first disabled? (Mo / Day / Year)

Is the Insured: Confined to their home? ☐ YES ☐ NO
Confined to bed? ☐ YES ☐ NO

Confined to a Medical Facility? ☐ YES ☐ NO If "Yes", complete the following:
NAME OF FACILITY | ADDRESS

List all physicians who have treated the Insured for this condition.

NAME OF PHYSICIAN	ADDRESS	DATE FIRST TREATED

Is the Insured totally disabled? ☐ YES ☐ NO | Date first disabled? (Mo / Day / Year) | Date last worked? (Mo / Day / Year)

Explain why this medical condition prevents the Insured from doing the substantial and material duties of his or her regular occupation.

Fair Credit Reporting Act - Pre-Notification Form

Public Law 91-508 requires that we advise you that an Investigative consumer report may be made in connection with this claim which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. Upon written request, a complete and accurate disclosure of the "nature and scope" of the report, If one ls made, will be provided,

AUTHORIZATION

I hereby certify that these answers are true and correct to the best of my knowledge. I understand that the completion of this form will not be construed as an admission by the Company of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract. l agree that any physician's statements, affidavits, or additional papers required by the Company will be made a part of this claim. I authorize any medical professional, medical care institution, insurance institution, consumer reporting agency or similar institution, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or other organization having records or knowledge of me or any member of my family, to release to Fidelity Life Association, or its reinsurers, any and all such Information it may require in the investigation of this claim I certify that I have received notification regarding the Fair Credit Reporting Act, and understand that I may request a personal interview by a consumer reporting agency, I hereby waive all right of confidentiality under state and federal credit privacy laws and release from liability the user as well as the person or firm providing such information. A photocopy of this authorization will be considered as effective and valid as the original.

Insured's Signature | Date

Owner's Signature | Date

Attending Physician's Statement

Patient Name | Account No. | Social Security No.

Diagnosis and Concurrent Condition | ICDA Code

Is condition due to injury or sickness arising out of patient's employment?
☐ YES
☐ NO

Pregnancy?
☐ YES
☐ NO

If "Yes", what is the expected delivery date?
Mo / Day / Year

Dates of services since disability commenced

Was patient hospitalized?
☐ YES ☐ NO

Name of Hospital | Address | City | State | Zip

Date Admitted: _____

Date Discharged: _____

Date symptoms first appeared or accident happened
Mo / Day / Year

Date patient first consulted you for this condition
Mo / Day / Year

Has patient ever had same or similar condition? ☐ YES ☐ NO If "Yes", when and describe.
Is patient still under your care for this condition? ☐ YES ☐ NO

Patient was totally disabled (unable to work)

From: _____ To: _____

Patient was partially disabled

From: _____ To: _____

If still disabled, date patient should be able to return to work
Mo / Day / Year

Patient was house confined

From: _____ To: _____

Was the patient referred to you? ☐ YES ☐ NO If "Yes", give the referring physician's name, address and phone number.
Physician's name | Address | Phone number

What are the patient's current restrictions?

Does patient have other health coverage? ☐ YES ☐ NO If "Yes", please identify.

Physician's Name (print) | Date

Signature | Degree

Address | City | State | Zip

Phone No. | Tax Identification No.

Fraud Notifications

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

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 fines and confinement in prison.

ALASKA: Any 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.

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.

ARKANSAS: 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.

CALIFORNIA: For your protection, California law requires the following to appear on this form: 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.

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: 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.

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..

FLORIDA: Any person who knowingly and with the 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.

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.

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.

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.

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..

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

MAINE, TENNESSEE, WASHINGTON or WEST VIRGINIA: 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.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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.

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

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 N.H. Rev. Stat. Ann. § 638:20.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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.

FRAUD NOTIFICATIONS CONTINUED

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.

OKLAHOMA: WARNING: Any person who knowingly, and with the 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.

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.

RHODE ISLAND: 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.

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.

VIRGINIA: Any person who, with the intent to defraud or knowingly that he/she is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

FOR RESIDENTS OF 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 enrollment form for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Claimant's Signature: _____ Date: _____

CHUBB

Authorization for the Release of Health Information

Combined Insurance Company of America, a Chubb company, is identified as "the Company" in this authorization document.

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the Information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or Information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.

I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosers of my health Information for purposes of treatment, payment or health care operations.

This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy. A copy of this authorization will be considered as valid as the original.

I acknowledge that I have received a copy of this authorization.

Patient Insured's Name/Signature | Date

Patient Insured's SSN | Patient Insured's Date of Birth | Patient Insured's Phone No.

Patient Insured's Address

Personal Representative's (if any) Name/Signature | Personal Representative's Phone No.

Personal Representative's (if any) Address

Description of Personal Representative's Authority or Relationship to Patient Insured

Policy or Contract Number

Claimants should retain a copy of this signed document for their records.