



ASSURANT

Employee  
Benefits

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## Disability Claim Statement—Life Insurance—Gardner & White

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Please read the following instructions carefully for proper completion of the attached Life Insurance Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion. If you also have Long Term Disability Insurance with Assurant Employee Benefits, completion of this form may not be necessary. Please contact Gardner & White for information.

Do not separate the pages of this Claim Statement. Additional physician's statements may be obtained from the Life Benefit Center, or by copying the physician's statement included in this statement. Attach any additional physician's statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. After the Employer and Claimant Statements are fully completed, forward the entire statement to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

**☞ If you live in the state of Arizona, the following statement applies to you:**

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.

**☞ If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**

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.

**☞ If you live in the state of California, the following statement applies to you:**

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.

**☞ If you live in the state of Colorado, the following statement applies to you:**

**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.**

**☞ If you live in the District of Columbia, the following statement applies to you:**

**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.

**☞ If you live in the state of Florida, the following statement applies to you:**

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

**☞ If you live in the state of New Jersey, the following statement applies to you:**

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

**☞ If you live in the state of Oregon, the following statement applies to you:**

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 may be guilty of insurance fraud.

**☞ If you live in a state other than mentioned above, the following statement applies to you:**

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.

***To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.***

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

Reply to: **Gardner & White Insured Claims Department**  
PO Box 40948 Indianapolis Indiana 46240-0948  
T 800.347.5737 F 317.587.0780

**GARDNER  
& WHITE**

Instructions for completion of the Employer's sections follow:

### Employer Claim Statement—Part 1

Please indicate at the top of the form whether or not this is a new claim.

- 1.–6. Self-explanatory.
7. Effective date of the claimant's Life coverage.
8. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.
9. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.
10. Provide the reason the claimant ceased working.
11. Self-explanatory.
12. Self-explanatory.
13. Any other coverages the claimant has with Assurant Employee Benefits. (i.e., Disability, Medical, Dental, etc.)
14. A–D If the claimant has returned to work, advise us of his/her **current** work schedule.  
Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.
- 15.–18. The claimant's basic annual earnings as of the determination date indicated in your Life policy. For #16, if the claimant receives any bonuses, commissions, or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.
- 19.–20. Self-explanatory.
21. Self-explanatory.
22. Self-explanatory.
23. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

### Employer Claim Statement—Part 2

**Fully** complete this section of the claim statement for **all** claims.

Please attach a copy of the employer's own description of the claimant's position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant's position. This section should be completed by someone who is familiar with the claimant's position; i.e. supervisor.

#### Physical Aspects

1. Self-explanatory.
2. Please tell us how often the claimant does each of the activities listed, and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.  
Never = 0 hours; Occasionally = 1/2–2-1/2 hours; Frequently = 2-1/2–5-1/2 hours;  
Continuously = 5-1/2 hours or more
- 3.–5. Self-explanatory.

#### Stress/Non Physical Aspects

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.

**Disability Claim Statement—  
Life Insurance—Gardner & White**



**Employer Claim Statement—Part 1**

Please print or type.

New Claim  Yes  No

1. Name of employer _____		2. Policy/Participation no. _____		3. Account no. _____	
4. Full name of claimant _____		5. Social Security no. _____	6. Date employed _____	7. Effective date _____	
8. Date last worked _____ Number of hours worked that day _____		9. Work schedule of claimant at time of disability: _____ days per week _____ hours per day			
10. Reason for not working after this date _____		11. Was plan effective when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please indicate date of termination _____			
12. Was claimant a member of a union at the time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
13. Does claimant have any other coverage(s) with Assurant Employee Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please advise of the type of coverage(s).					
14.A. Is the insured engaged in any gainful employment, even in a limited way? <input type="checkbox"/> Yes <input type="checkbox"/> No					
B. If "Yes," please provide the following information: Date insured returned to work _____ Number of hours currently working per week _____ Current salary _____ If the insured returned to work with another employer, please provide us the name and address of this employer. _____					
C. Have you and the claimant discussed reasonable accommodations which would allow a return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain.					
D. If "No," on approximately what date do you expect the insured to be able to return to work, if ever? _____					
15. Basic annual salary (as defined in Policy) _____			16. How is claimant paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary + Commission <input type="checkbox"/> Salaried <input type="checkbox"/> Commission Only <input type="checkbox"/> Salary + Bonus <input type="checkbox"/> Other _____		
17. Date of last increase in the amount of life insurance _____			18. Amount of life insurance as of date last worked \$ _____		
19.A. Has the employment of the insured been terminated solely because of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
B. If "Yes," please give date employment was terminated. _____					
C. If "No," please explain present employment status. _____					
20. If your group plan is on a self-administered basis, please indicate:					
A. Date of last premium paid by or on behalf of insured _____					
B. Mode of premium payment: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually					
21. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources?					
<input type="checkbox"/> Salary continuance		Amount: _____ per _____		From _____ to _____	
<input type="checkbox"/> Workers' Compensation		Weekly benefit _____		Effective date _____	
<input type="checkbox"/> Retirement or pension		Benefit amount _____		Effective date _____	
<input type="checkbox"/> Other _____		Lump sum distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No			
22. Remarks _____					
23.					
Date _____		By _____ AUTHORIZED SIGNATURE/TITLE			
Fax no. _____		Phone no. _____			



**Claimant Statement—Part 1** Please Print or Type.

**Section I**

1. Full name		2. Social Security no.		3. Date of birth	
4. Address (city, state, zip code)				5. Home phone no.	
6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			8. Your occupation	

**Section II**

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred.		2. Date first unable to work because of this disability.		
3. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date: _____ Part-time _____ Full-time If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time				
4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.				
Name		Address	Dates of consultation First Visit	Last Visit
5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.				
Name of Hospital		Address	From	To

**Section III**

1. A. Has your condition prevented you from doing any job for which your education, training or experience qualifies you? <input type="checkbox"/> Yes <input type="checkbox"/> No
B. If "Yes," since what date has disability been total and continuous? _____
C. Are you receiving or have you applied for Social Security Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ineligible If ineligible, explain _____
<b>(Please forward a copy of Award or Denial letter from Social Security as soon as it is available.)</b>
2. A. Do you expect your disability to be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No
B. If "No," about when do you expect to recover or be able to engage in any gainful occupation? _____
Please indicate the type of coverage provided (Check all that apply.): <input type="checkbox"/> Employer Group <input type="checkbox"/> COBRA <input type="checkbox"/> Conversion <input type="checkbox"/> Individual <input type="checkbox"/> Spouse <input type="checkbox"/> Government <input type="checkbox"/> Other (Specify) _____

**Section IV**

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representatives, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Signature of claimant \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT DETACH**

**Claimant Statement—Part 2** (Do not complete this section if you have returned to work, or if disability is for pregnancy.)

**Training, Education & Experience**

<p>1. What is your level of education?</p> <p>A. Have you received a high school diploma or the equivalent of a high school diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please advise us of the last grade completed. _____ grade</p> <p>B. Have you attended college? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some college <input type="checkbox"/> College graduate <input type="checkbox"/> Post graduate</p> <p>Please specify: Major field of study _____ Degree earned _____ Date last attended _____</p> <p>C. Have you attended any trade schools or received any other special training? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: Type of training _____ Date last attended _____</p>
<p>2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.</p>
<p>3. What was your occupation when disability commenced and what were the usual duties of your occupation?</p>
<p>4. Which of the above job duties are you unable to perform?</p>
<p>5. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Have you asked your employer to provide any accommodations which would allow you to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what accommodations did you request and what was your employer's response?</p>
<p>7. What accommodations do you feel could be made by your employer to allow you to return to work?</p>
<p>8. Have you considered retraining? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what vocational area(s) would interest you?</p>
<p>9. Please list any hobbies, outside interests or activities.</p>
<p>10. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name, address and phone number of the counselor handling your case?</p>
<p>11. Have you contacted your state Division of Vocational Rehabilitation Department? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name, address and phone number of the counselor handling your case?</p>

The patient must pay any costs for completion of this form.

**To the Attending Physician**

Please read the following instructions before completing this form.

**Do not separate the pages of this claim statement.** An authorization to release information can be found in Part 1 of the Claimant's Statement.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the reverse side of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient _____		Date of birth _____	Social Security number _____
<b>History</b>	Patient's symptoms result from ( <i>Check all that apply.</i> ): <input type="checkbox"/> Employment <input type="checkbox"/> Illness		
	<input type="checkbox"/> Auto accident ( <i>state in which accident occurred</i> ) _____		<input type="checkbox"/> Other accident _____
	<input type="checkbox"/> Pregnancy ( <i>expected/actual delivery date</i> ) _____		Type of delivery _____
	Date symptoms first appeared _____		Patient's height _____ Weight _____
	First visit for this condition _____		Most recent visit _____ Most recent comprehensive exam _____
	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other ( <i>Specify.</i> ) _____		
	Name(s) and address(es) of other treating or referring physician(s) _____		
<b>Diagnoses</b>	Hospital name _____ Confinement dates _____ thru _____		
	Diagnoses ( <i>including any complications</i> ) _____		
	Subjective symptoms _____		
	Objective findings ( <i>Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.</i> ) _____		
<b>Treatment</b>	Attach medical records as appropriate.		
	Describe treatment program, including dates of any surgery, medications, physical therapy or psychotherapy. _____		
<b>Psychiatric Impairment</b>	<b>Complete only if applicable.</b>		
	<input type="checkbox"/> Class 1—Patient is able to function under stress and engage in interpersonal relations ( <i>no limitations</i> ).		
	<input type="checkbox"/> Class 2—Patient is able to function in most stress situations and engage in only limited interpersonal relations ( <i>slight limitations</i> ).		
	<input type="checkbox"/> Class 3—Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations ( <i>moderate limitations</i> ).		
<input type="checkbox"/> Class 4—Patient is unable to engage in stress situations or engage in interpersonal relations ( <i>marked limitations</i> ).			
<input type="checkbox"/> Class 5—Patient has significant loss of psychologic, physiological, personal and social adjustment ( <i>severe limitations</i> ).			
<input type="checkbox"/> Remarks _____			
What stress and problems in interpersonal relations has patient had on the job? _____			
Do you believe a legal guardian or conservator should be appointed for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

