FORT DEARBORN LIFE
Insurance Company®

Toll Free: (855) ERS-LIFE (377-5433)
Fax # (972) 996-9361

Disability Claim Instructions

Submit to Fort Dearborn Life Insurance Company®
Administrative Office:
P.O. Box 655403
Dallas, Texas 75265-5403

Employee

- Complete identifying information in the **Employee's Preliminary Statement of Disability** (page 2 of this claim form) and send the form to your Benefits Coordinator for completion of the Employer's section.
- Your employer will return the claim form to you for further handling.
- When your Benefits Coordinator returns the claim form to you, complete, sign, and date page 2 and 4 of the form. The signed **Claimant Authorization** on page 4 will allow FDL or its representative to obtain additional information which may be required to complete the processing of your claim.
- Take the entire claim form (pages 1, 2, 3 and 4) to your treating physician, who must be an Approved Practitioner.
- Your physician must fully and legibly complete the **Attending Practitioner's Statement** on page 3 of this claim.
- Send completed claim form and all additional information to FDL at the address shown above. FDL must receive the form within 12 months of the date your Total Disability began.

Attending Practitioner

- In order to avoid a delay or possible denial of your patient's claim, all information must be legibly completed in full.
- To qualify for Total Disability your patient must have a documented **"medically determinable"** impairment.
- The Attending Practitioner's Statement **must** contain objective clinical findings which document the impairment causing "Disability" and any co-morbid conditions. In cases involving mental impairments the clinical information must include your patient's capacity for understanding and memory, social interaction and adaptation medications and frequency of therapy.
- **Totally Disabled from "Own Occupation"** means the inability of the insured, because of an injury or sickness established by medical evidence based on objective clinical findings using current AMA guidelines and certified by an approved practitioner, to perform the usual tasks of his or her occupation in such a way as to procure and retain employment. **Totally Disabled from "Any Occupation"** means the inability of the insured to perform the usual tasks of any compensated occupation for which he or she is reasonably suited by training, education or experience, in such a way as to procure employment. This definition will govern the determination of benefits.

Employer

- Complete the Employer's Section below and attach (1) Job description (detailed duties) (2) Time records from last day worked to present. **Return claim form and attachments to the employee.**

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Employer's Section

Employee ID# _____

Employee Name _____ Social Security # _____ Policy No. 38000_____

Date of hire _____ Short-term Disability Eff. Date _____ Long-term Disability Eff. Date_____

Last day at work _____ Occupation _____

Date returned to work F/T_____P/T_____

Return to Work Occupation_____

Eligible for sick leave or extended sick leave? Y☐ N☐ Duration _____

Eligible for salary continuation? Y☐ N☐ Amount $_____ Duration _____

Eligible for Short-term Disability benefits from another carrier? Y☐ N☐ Name of Carrier _____

Is employee eligible for pension disability? Y☐ N☐ Is this employee eligible for workers' compensation? Y☐ N☐

Employer Name _____

Employer Address _____

Representative Name _____ Signature _____

Title _____ Telephone Number _____ Date_____

Did the employer pay any portion of the employee's Short-term Disability premium? Y☐ N☐ If yes, what _____%

Did the employer pay any portion of the employee's Long-term Disability premium? Y☐ N☐ If yes, what _____%

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Employee's Preliminary Statement of Disability *Please print or type*

Full Name _____ Social Security # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Date of birth _____ Height _____ Weight _____ Sex M ☐ F ☐
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Spouse's date of birth _____ Is spouse employed? Y ☐ N ☐ Number of children (under the age of 18) _____

Name and date of birth of each unmarried child under age 18 _____

_____

Describe the symptoms of your disability _____

_____

Is your disability related to a work injury? Y ☐ N ☐ If yes, please give details_____

_____

Date you first noticed symptoms of illness or date of accident _____ Date first treated for these symptoms _____

Treated by Doctor: _____ Address _____ Phone _____

Hospital _____ Address _____ City _____

I have been unable to work because of this illness or injury since _____

If disability is due to an accident, please provide details and attach accident report _____

_____

I returned to work part-time on _____ I returned to work full-time on _____ I am self employed Y ☐ N ☐

Name of Health Care Insurance _____ Group Plan/Policy # _____

ID # _____ Coverage is through My employer ☐ Spouse's employer ☐

Are you now eligible for, have you applied for, or are you now receiving income benefits from:
Social Security: Disability ☐ Retirement ☐ Amount awarded $_____ Date of award _____
Workers' Compensation ☐ Amount awarded $_____ Date of award _____ Carrier _____
(If Workers' Compensation is denied submit a copy of denial letter with this form)
Disability Retirement ☐ Amount awarded $_____ Date of award _____ Source _____
Have you ever had the same or similar condition? Y ☐ N ☐
If so, when? _____Treated by_____
List all Practitioners you have seen for the past 2 years:

- Name_____ Address_____ Telephone _____
  From _____To _____ Diagnosis/Condition Treated_____
- Name _____ Address_____ Telephone _____
  From _____To _____ Diagnosis/Condition Treated_____
- Name _____ Address_____ Telephone _____
  From _____To _____ Diagnosis/Condition Treated_____

Are you employed elsewhere? Y ☐ N ☐ Full time ☐ Part time ☐
If yes to above question please give: Name of 2nd Employer _____
Address _____ City _____ St _____ Zip _____
Name of person completing this form if other than the employee _____

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

_____ _____
Employee's signature (required to process the claim) Date

Attending Practitioner's Statement *Please print or type*

All information must be legibly completed in full to avoid a delay or possible denial of your patient's claim.

Patient's name _____ Patient's Date of Birth _____
Date first seen _____ Date last seen _____ frequency of visits PRN ☐ weekly ☐ monthly ☐ less often ☐
Patient impaired from tasks of his/her usual occupation from _____ to _____
Diagnosis _____ ICD9CM code _____
Co-morbid conditions _____
If diagnosis is pregnancy: LMP _____ Estimated delivery date _____ Is patient confined to bedrest? Y ☐ N ☐
If delivered, date _____ Type of delivery: Normal ☐ C-section ☐
Subjective symptoms _____
_____
Objective medical findings, include results of all diagnostic testing _____
_____
_____
_____
Objective evidence of impairment _____
_____
_____
Please list restrictions _____
_____
Please describe how the patient's impairment prevents him/her from performing their regular employment _____
_____
Is disability at patient's request? Y ☐ N ☐ Is condition work related? Y ☐ N ☐
Plan of Treatment _____
_____
Medications _____
_____
Does the patient's condition permit the safe operation of a vehicle? Y ☐ N ☐ Patient has been instructed not to drive ☐
Is the patient Ambulatory? Y ☐ N ☐ Only with assistance ☐ Confined to? Bed ☐ House ☐ Hospital ☐
List names and phone number of other treating or consulting Practitioners _____
_____
List the date and facility of any hospital admission in the past 12 months including dates, type of surgery, condition, etc.
_____
_____
How does the patient's impairment prevent alternative/other employment _____
_____
Was the patient unable to work when he/she ceased work? Y ☐ N ☐
Disability applies to: Only the patient's own job Y ☐ N ☐; all other types of work, including sedentary work? Y ☐ N ☐
Date patient is expected to be able to return to his/her usual work _____ Other work _____

I attest the above statements are true and complete to the best of my knowledge

_____ _____ (_____) _____
Name (Attending Practitioner) Degree & Specialty Telephone

_____ _____ _____ _____
Street Address City or Town State ZIP

_____ _____
Attending Practitioner's Signature Date

Fort Dearborn Life Insurance Company®
Claimant Authorization

I, the undersigned claimant, have read and agree that the above statements and answers are furnished in support of my claim for benefits and are complete, true, and correctly recorded to the best of my knowledge and belief. I understand that incorrect or untrue answers on this form may result in denial of this claim and may be cause for expulsion from the Texas Employees Group Benefits Program.

I understand and agree that:

- This authorization is voluntary but that my signature is required in order for Fort Dearborn Life Insurance Company (the "Company") to evaluate my claim for benefits;
- If I refuse to sign this authorization, the Company has the right to deny my claim, or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire the later of 24 months from the date signed or at the end of any appeal process concerning my claim.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from the Company.

I authorize my employer, the Employees Retirement System of Texas ("ERS"), and any medical professional, hospital, medical facility, medical provider, pharmacy, government agency, insurance carrier, HMO, MCO, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's claims department or its authorized representative(s) any information relating to me concerning advice, care, or treatment, including any claims processed by Blue Cross Blue Shield of Texas, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus), or other sexually transmitted diseases.

I authorize my employer, ERS, any government agency, or insurance carrier to disclose any information related to my employment or retirement and all other information necessary to process my claim.

WARNING: 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.

Employee/Insured's Name _____
(Print or Type)

Signature _____Date _____