LifeMap Assurance Company™
P.O. Box 1271, M/S E3A
Portland, OR 97207

Administered by: **Disability RMS**
Disability Reinsurance
Management Services, Inc.
One Riverfront Plaza
Westbrook, ME 04092-9700

(877) 254-0085
Fax (207) 591-3048
claims@disabilityrms.com

Statement of Long Term Disability

Claim Filing Instructions

This Statement of Long Term Disability (LTD) includes the forms required to apply for LTD benefits.
If a form is received incomplete, unsigned or undated, it will be returned to you for completion.

Have you…

1. completed in full, signed and dated the Employee's Statement?
2. signed and dated the Authorization for Release of Information?
3. had the physician treating you complete, sign and date the Attending Physician's Statement, and had it returned to you?
4. had your Employer complete, sign and date the Employer's Statement, and had it returned to you?

You are responsible for ensuring all forms are completed and returned to Disability RMS.

Forms can be sent to Disability RMS via:

Email: **claims@disabilityrms.com**

Fax: **(207) 591-3048**

Regular Mail: **Disability RMS**
One Riverfront Plaza
Westbrook, Maine 04092

If you have any questions, please call Disability RMS at (877) 254-0085.

Please note, you must notify Disability RMS promptly if:

- Your medical condition improves so that you would be able to work, even though you have not yet returned to work.
- You go to work in any capacity for any employer, or as a self-employed person.

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Employee's Statement

Employee

Employee Name (Last, First, Middle Initial)				Social Security Number
Employee Mailing Address	Street & Number	City	State	Zip

Home Phone Number ( )	Cell Phone Number ( )	Date of Birth	☐ Male ☐ Female	☐ Right-handed ☐ Left-handed

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Is your spouse employed? ☐ Yes ☐ No	Number of dependent children:	Names and dates of birth of spouse and dependent children:

Employment

Employer Name	Employer Phone Number ( )	Policy Number

Employer's Mailing Address	Street & Number	City	State	Zip

Your Occupation & Title	List essential duties of your job at the time of disability:

How many hours were you regularly working per week with your present employer?	Gross Annual Salary (not including overtime) during the 12 months just prior to your disability – for this employer only: $	Please indicate how you are paid (check all that apply): ☐ hourly ☐ salaried ☐ other _____ ☐ bonuses ☐ commissions

Date you returned (or expect to return) to work on a part-time basis:	Date you returned (or expect to return) to work on a full-time basis on:

Medical Information

Date First Treated:	First date unable to work because of disability:
Date of injury or date first noticed symptoms of illness:	Have you ever had the same or similar condition in the past? ☐ No ☐ Yes, when?

Is your injury or illness related to your occupation? ☐ Yes ☐ No ☐ Unsure	Did you file for workers' compensation? ☐ Yes ☐ No ☐ Not Yet	Workers' compensation claim status: ☐ Pending ☐ Approved ☐ Denied (include copy of denial letter)

Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms (If more space is needed, please attach sheet of paper.):

Attending Physician

Primary Physician:				Phone Number ( )	Hospital	
Street Address	City	State	Zip	Fax Number ( )	Date Admitted	Date Discharged

Please complete the following page.

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Statement of Long Term Disability

Employee's Statement (continued)

Employee Name (Last, First, Middle Initial)	Social Security Number

Other Sources of Income

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

Type	Amount	Date Began	Date Ended	Type	Amount	Date Began	Date Ended
Sick Pay				Salary Continuance			
Social Security (SSA) (disability or retirement)				Retirement Income (normal, early or disability)			
SSA Dependent's				State Disability			
Workers' Compensation				Unemployment Compensation			
Local, State or National Association or Society Disability Income Plan				Other STD/LTD Benefits:			
				Other (describe):			

Have you applied, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type: Date Application Filed:

Type: Date Application Filed:

Tax Withholding (if your LTD benefits are taxable)

If your request for benefits is approved, do you want us to withhold federal income taxes? ☐ Yes ☐ No
Indicate amount to withhold: $ (per month) **OR** Indicate filing status: ☐ Married ☐ Single **AND** number of deductions:

If your request for benefits is approved, do you want us to withhold state income taxes? ☐ Yes ☐ No
Indicate amount to withhold: $ (per month) **OR** Indicate filing status: ☐ Married ☐ Single **AND** number of deductions:

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notice on page 4 of this form.

▶ _____ ▶ _____
Employee's Signature Date

Complete Authorization for Release of Information form on page 5.

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Statement of Long Term Disability

Authorization for Release of Information
(To be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of LifeMap Assurance Company (LifeMap) and to its authorized claims administrator, Disability Reinsurance Management Services, Inc. (Disability RMS), *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by LifeMap and/or Disability RMS and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing LifeMap and/or Disability RMS solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying LifeMap and/or Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that LifeMap and/or Disability RMS have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the ability of LifeMap and/or Disability RMS to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

- If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).
- If you reside in Minnesota or Wisconsin: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.
- If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.
- If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING LifeMap and/or DRMS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and LifeMap and/or DRMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

▶ _____ ▶ _____
Employee/Primary Insured's Full Name (please print clearly) | Social Security Number

▶ _____ ▶ _____
Employee/ Primary Insured's Signature | Date Signed

If signature is provided by legal representative (e.g. Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Employer's or Administrator's Statement

Information about Employee

Employee Name (Last, First, Middle Initial)	Job Title	Class

Date Employed:	Date Last Worked:	Date of Termination: ☐ N/A

Reason for stopping work: ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired
☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason: _____

Date returned to work: Full-time: Part-time:	If part-time, number of hours worked per week:	If employee has not returned to work, estimated return to work date:

Employee's Earnings: $	Regular scheduled hours per week:	Is disability due to employment?
Earnings prior to increase: $	Date of last increase:	☐ Yes ☐ No ☐ Unsure
☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ shift differential ☐ bonuses ☐ other:		Has Workers Compensation claim been filed? ☐ Yes ☐ No ☐ Not yet

Information about Employee's Long Term Disability Coverage

Employee Long Term Disability coverage: Effective Date: Termination Date:	What percentage of the LTD premium does the **Employer** pay? _____% Are employer paid premiums included in employee's salary? ☐ Yes ☐ No Is **employee** contribution: ☐ Pre-Tax Deduction ☐ After-Tax Deduction

Other Benefits and Sources of Income

Employee Eligible for:

Type	Amount	Date Began	Date Ended	Type	Amount	Date Began	Date Ended
Sick Pay				Salary Continuance			
Social Security (SSA) (disability or retirement)				Retirement Income (normal, early or disability)			
SSA Dependent's				State Disability			
Workers' Compensation				Unemployment Compensation			
Local, State or National Association or Society Disability Income Plan				Other STD/LTD Benefits:			
				Other (describe):			

Additional Documentation (Please attach a copy of the following documents to this form.)

- The employee's current job description
- The employee's Workers' Compensation claim(s) and Approval/Denial Notification, if applicable

Information about Employer

Employer Name	Location Code (if applicable)	Policy Number

Employer Address Street & Number City State Zip	Phone Number ( )

Name and title of employer representative completing this form	Email Address

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 7 of this form.

▶ _____ ▶ _____
Employer Representative's Signature Date

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Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to insurance company.

Patient Information

Employee Name (Last, First, Middle Initial)		Social Security Number	Employer Name
Height	Weight	Blood Pressure/Date Taken	☐ Left-handed ☐ Right-handed

Information about Diagnosis

Diagnosis	ICD Code(s)
Symptoms	
Comorbid Conditions	
Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings)	
Date symptoms first appeared or injury occurred:	Date you recommended the patient stop working:
Patient's condition is due to: ☐ Illness ☐ Accident	Has patient ever had the same or a similar condition? ☐ Yes ☐ No If Yes, when
Is condition arising out of patient's employment? ☐ Yes ☐ No	Did you complete Workers' Compensation claim form? ☐ Yes ☐ No

Information about Treatment

Date of first visit for this condition:	Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____	Next office visit:
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)		

Hospital Admission Date:	Hospital Discharge Date:	Was Surgery Performed? ☐ Yes ☐ No	Date of Surgery:
Name of Procedure:		Surgery/Post-Operative Complications: ☐ Yes ☐ No If yes, please describe:	

Was patient treated by another provider(s) for this disability? ☐ Yes ☐ No
If Yes, please provide dates, name and address of provider(s):

For Pregnancy Disability Only

Date of Last Menstrual Period	Expected Date of Delivery	Actual Date of Delivery	☐ Vaginal ☐ C-Section

Are there any present complications or anticipated difficulties:
Pregnancy ☐ Yes ☐ No Delivery ☐ Yes ☐ No Post Partum ☐ Yes ☐ No
If "Yes" to any of these, please describe in detail:

Please complete the following page.

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Statement of Long Term Disability

Attending Physician's Statement (continued)

Employee Name (Last, First, Middle Initial)

Assessment of Physical Impairment (as defined in the Federal Dictionary of Occupational Titles)

- ☐ Class 1 -- No Limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
- ☐ Class 2 -- Medium manual activity* (15-30%)
- ☐ Class 3 -- Slight limitation of functional capacity; capable of light work* (35-55%)
- ☐ Class 4 -- Moderate limitation of functional capability; capable of clerical/administrative (sedentary) activity* (60-70%)
- ☐ Class 5 -- Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)

Assessment of Mental Impairment (if applicable)

- ☐ Class 1 -- Patient able to function under stress and able to engage in interpersonal relations (No limitations).
- ☐ Class 2 -- Patient able to function in most stress situations and engage in limited interpersonal relations (Slight limitation).
- ☐ Class 3 -- Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation).
- ☐ Class 4 -- Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation).
- ☐ Class 5 -- Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation).

Assessment of Current Functional Ability

Describe current restrictions (activities which should not be performed by the patient):

Describe current limitations (activities which cannot be performed by the patient):

Related to a mental health condition, describe behaviors, attitudes or functional impairments that are contributing to the patient's restrictions and/or limitations:

Describe factors delaying recovery (if applicable): ☐ Malingering ☐ Exaggeration ☐ Other, please specify:

Is the patient competent to manage insurance benefits? ☐ Yes ☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

Return to Work Plan

Date you released patient to return to work:	☐ Full Time ☐ Modified Duties ☐ Part Time ☐ Reduced Hours	Number of hours per week:

How long do you expect these limitations and restrictions to impair your patient?

☐ Date: ☐ Unable to determine, follow up appointment: ☐ Permanently

Please identify your recommendations for any job modifications that would enable the patient to work:

Information about Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number ( )
Office Address	City State Zip	Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 10 of this form.

▶ _____ ▶ _____
Attending Physician's Signature Date

Please return completed form to your patient.

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Maine, Tennessee, Virginia and Washington Residents: 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.

Alaska, Kansas and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: 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.