



**Return to Fort Dearborn Life at:**

Attention: Claims Department

1020 31st Street

Downers Grove, Illinois 60515-5591

**Phone Number:** (800) 348-4510

**Fax:** (630) 824-5419

**PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED**

GROUP NUMBER \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> SHORT-TERM DISABILITY | <input type="checkbox"/> ACCIDENTAL DISMEMBERMENT  |
| <input type="checkbox"/> VOLUNTARY STD         | <input type="checkbox"/> SPECIFIC DISEASE BENEFIT  |
| <input type="checkbox"/> WAIVER OF PREMIUM     | <input type="checkbox"/> ACCELERATED DEATH BENEFIT |
|  | <input type="checkbox"/> CRITICAL ILLNESS          |

**CLAIMANT'S STATEMENT (Please Print)**

|                  |        |                   |             |            |              |
|------------------|--------|-------------------|-------------|------------|--------------|
| Claimant's Name  |        | Social Security # | Height      | Weight     | Birth Date   |
| Address          |        |                   |             |            | Phone Number |
| Number           | Street | City              | State       | Zip        | A/C ( )      |
| E-mail           |        |                   |             |            |              |
| Name of employer |        | Occupation        | Maiden Name | Alias Name |              |

Are you filing a claim for this disability under the Workers' Compensation Act?  Yes  No

Are you filing a claim for this disability under the Social Security Act?  Yes  No

Describe other income you are receiving:

| YES                      | NO                       | TYPE *                                     | AMOUNT   | DATE BENEFITS BEGAN | DATE BENEFITS TERMINATED | NAME OF INSURANCE CARRIER |
|--------------------------|--------------------------|--|----------|---------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Social Security (disability or retirement) | \$ _____ | _____               | _____                    | _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | State disability                           | \$ _____ | _____               | _____                    | _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Retirement (normal, early or disability)   | \$ _____ | _____               | _____                    | _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Workers' Compensation                      | \$ _____ | _____               | _____                    | _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Group disability benefits                  | \$ _____ | _____               | _____                    | _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____                     | \$ _____ | _____               | _____                    | _____                     |

*\*Please send a copy of your award letter, if applicable.*

1. Date of accident or beginning of sickness: \_\_\_\_\_ Date last worked: \_\_\_\_\_

2. Nature of injury or illness: \_\_\_\_\_

3. If injury, describe how, when and where accident occurred: \_\_\_\_\_

4. Have you ever had same or similar illness?  Yes  No If yes, give dates: From \_\_\_\_\_ To \_\_\_\_\_

5. Name of hospital(s): \_\_\_\_\_ Dates confined: From \_\_\_\_\_ To \_\_\_\_\_

Address of hospital(s): \_\_\_\_\_

6. Name and address of Doctor(s): \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

7. Between what dates were you unable to perform any duties? From \_\_\_\_\_ To \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**AGREEMENTS AND AUTHORIZATION:** I authorize my employer to disclose all information necessary to process my claim to Fort Dearborn Life Insurance Company (FDL).

I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's claim department or its authorized representative(s) information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize FDL to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

This authorization shall expire on the date that I receive notice of FDL's final decision on my claim. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records.;
- A photocopy of this authorization shall be as valid as the original;

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

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny my claim.

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. (Not enforceable in Oregon or Virginia.)

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_



**Phone Number:** (800) 348-4510

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**Employers Statement** (*\*\*italicized items should only be completed if the claim is for Waiver of Premium*)

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Employee's Name   |  | Social Security #   | Date of Hire  | Effective date of Employee's insurance |  |
| Employer's Name   |  |   | Employer's Group Number   |  |  |
| Employer's Address  |  |   |   |  |  |
| Employer's E-mail Address   |  |   |   |  |  |
| Last Day Worked   | <input type="checkbox"/> FT<br><input type="checkbox"/> PT | Date returned   | <input type="checkbox"/> FT<br><input type="checkbox"/> PT  | Base salary                            | <input type="checkbox"/> Hourly<br>\$ _____<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Monthly |
| Worker's Comp Claim filed for this Disability?  |  | SELF ADMINISTERED ONLY: Amount of weekly disability benefit: \$ _____ |   | Class                                  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   | Hours worked per week                  |  |
| Employee's Occupation   |  |   | Claimant received: Salary continuation through _____<br>Vacation through _____ Sick Pay through _____ |  |  |
| Premium contribution % by Employer _____ Employee _____ Employee premiums for this coverage pre-taxed? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |  |  |
| **Amount of Life Insurance in force:  |  | **Through what date were premiums paid:                               |   | **Normal retirement age:               |  |
| Signature   |  | Title   | Date  | Telephone ( )                          |  |

**ATTENDING PHYSICIAN'S STATEMENT**

(Must be completed in full at the patient's expense)

|   |                                 |               |     |
|---|---------------------------------|---------------|-----|
| Patient's Name _____                                  | <input type="checkbox"/> Male   | Date of Birth | Age |
| Street Address _____ City _____ State _____ Zip _____ | <input type="checkbox"/> Female |               |     |

- Nature and origin of  sickness  injury Diagnosis (describe complications, if any): \_\_\_\_\_
- Date symptoms first appeared or date of accident: \_\_\_\_\_ Date patient first consulted you for this condition: \_\_\_\_\_
- Is this condition work related?  Yes  No \_\_\_\_\_
- Describe any other disease or complications effecting present condition: \_\_\_\_\_
- Date and surgical procedure(s), if any: \_\_\_\_\_
- If maternity give estimated or actual date of delivery: \_\_\_\_\_  Vaginal  C-section
- Please give dates of treatment other than surgical: \_\_\_\_\_
- Please give hospital name & address with dates of confinement: From \_\_\_\_\_ To \_\_\_\_\_  Inpatient  Outpatient  
Hospital Name \_\_\_\_\_ Address \_\_\_\_\_
- Has patient ever had same or similar condition?  Yes  No (If yes, state when and describe) \_\_\_\_\_
- Is patient still under your care?  Yes  No (If discharged give date and degree of recovery) \_\_\_\_\_
- Is the patient under the care of another physician?  Yes  No (If yes, provide name, address and phone # of physician) \_\_\_\_\_
- Patient was or will be continuously disabled (unable to work)  
In his/her own occupation From \_\_\_\_\_ Through \_\_\_\_\_ In any other occupation From \_\_\_\_\_ Through \_\_\_\_\_  
Patient can return to work  Full time  Part time on \_\_\_\_\_  Restrictions (specify) \_\_\_\_\_
- Patient was or will be partially disabled? \_\_\_\_\_ From \_\_\_\_\_ Through \_\_\_\_\_
- In your opinion, is patient a candidate for rehabilitation?  Yes  To return to own occupation  For another occupation  No
- If patient is diagnosed as terminal, is life expectancy:  6 months or less  12 months or less  Other \_\_\_\_\_

Remarks: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Office # ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Specialty: FP  IM  PM&R  Neuro  Ortho  OBG  Psych  Other \_\_\_\_\_



**The laws of some states require us to furnish you with the following notice:**

**Arizona & New Jersey - Claims**

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

**Arkansas & Massachusetts**

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.

**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, Idaho & Oklahoma**

Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

**District of Columbia & Virginia**

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 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.

**Louisiana & 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.

**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 RSA 638:20.

**New Jersey - Applications**

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

**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.

**Washington**

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.

**All Other States**

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. (not enforceable in OR)