



CUSTOM DISABILITY SOLUTIONS



Harleysville Life Insurance Company

GROUP DISABILITY CLAIM APPLICATION

Short Term Disability (STD)

SEND TO:

CUSTOM DISABILITY SOLUTIONS

P.O. BOX 9461

PORTLAND, ME 04104-5056

TEL: (888) 234-2641

FAX: (800) 293-4781

Long Term Disability (LTD)

SEND TO:

CUSTOM DISABILITY SOLUTIONS

P.O. BOX 9461

PORTLAND, ME 04104-5056

TEL: (877) 448-1999

FAX: (207) 883-8641

To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

- Section 1: Authorization (to be completed by you, the employee)
- Section 2: Employee's Statement
- Section 3: Employer's Statement
- Section 4: Physician's Statement

When ALL sections of this form have been completed, please fax or mail it to us. Use the fax number or address above that corresponds to the type of disability for which you are applying.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

P.O. Box 9461 TEL: (888) 234-2641 STD; (877) 448-1999 LTD
Portland, ME 04104-5056 FAX: (800) 293-4781 STD; (207) 883-8641 LTD

Section 1: To Be Completed By Employee

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

TO:

- Physicians and other Medical Professionals
Consumer Reporting Agencies
Employers
Group Policyholders, Contract Holders/Vendors, Health Benefit Plan Administrators or their successors
Governmental Agencies (including and not limited to the Social Security Administration, Veteran's Administration, Railroad Retirement Board and Jones Act Administration)
Hospitals and other Medical Care Institutions
Insurers
Prepaid Health Plans
State Vocational Rehabilitation agencies and other providers of Rehabilitation Services
Medical Information Bureau (MIB) or other companies which collect health and insurance claim information

You are authorized to provide any information related to my medical condition and to job modifications/accommodations with my current or future employer to:

- Custom Disability Solutions ("CDS"),
The plan administrator or claim administrator of any benefit plan under which I may be a participant, or
Claims investigators, attorneys, and service consultants and other personnel involved in the administration, evaluation, analysis and management of the plan and/or claim.

This includes, but is not limited to, any:

- Records, test results, data, and information about medical care, history, diagnosis, prognosis, treatment, and supplies
Employment-related information
Income-related information
Information from credit reporting bureaus or other consumer reporting agencies
Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I understand that the Information will be used for the purpose of evaluating, analyzing, managing and / or administering my claim for short term disability benefits, long term disability benefits, salary continuation, workers' compensation and/or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), for assessing and developing a vocational rehabilitation plan, and for other business purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program plan under which I may be a participant, claims investigators, attorneys, service consultants and any other entities, including the claimant's treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program.

I understand that this authorization shall remain in force for the duration of my claim for benefits under the Benefits Program or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed. I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of my initial authorization, may impair the ability of CDS or another claim administrator to process my claim and may be a basis for denying or terminating my claim for benefits.

Claimant's Signature: _____ Claimant's Date of Birth: _____
Claimant's Full Name: _____ Employer: _____
Claimant's Address: _____ Date: _____

CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including California, Connecticut, Florida, New Jersey, New York, Pennsylvania and others, require the following statements:

***For residents in all states except
California, Connecticut, Florida, New Jersey, New York, and Pennsylvania***

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For California residents

Any person who knowingly presents a false or fraudulent claim for the payment of a loss 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.

For Connecticut residents

Any person who knowingly presents false or fraudulent claim, as determined by a court of competent jurisdiction, 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.

For Florida residents

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.

For New Jersey residents

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

For New York residents

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Pennsylvania residents

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 and subjects such person to criminal and civil penalties.

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
 Write "NA" in non-applicable sections.

1 Employee Name		2 Social Security No.	
Street/Box/Apt.		3 Phone No. ()	
City, State, Zip		4 Date of Birth	
5 Height	6 Weight	7 <input type="checkbox"/> Male <input type="checkbox"/> Female	8 Employer Name
9 Occupation	10 List Occupation Duties		
11 Date of accident or date of first symptoms		12 Last Day Worked	13 Are you unable to work due to: (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy
14 Date you Returned to Work			<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
15 If you have not returned to work, when do you expect to return?			<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
16 Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms			

17 Is your accident or illness related to your occupation? Yes No
 If yes, explain:

18 Have you filed a Workers' Compensation Claim? Yes No If no, do you intend to? Yes No
 If no, explain:

19 When were you first treated for your illness or accident?

Hospital	Address	Date(s)
Doctor	Address	Date(s)

20 Have you ever had same or similar condition in the past? Yes No If yes, list name and address of Hospital/Doctor below

Hospital	Address	Date(s)
Doctor	Address	Date(s)

21 Are you receiving any of the following? (Check each benefit you are receiving)

	Amount	Begin date	End date		Amount	Begin date	End date
<input type="checkbox"/> Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/> Unemployment	\$ _____	_____	_____
<input type="checkbox"/> Social Security	\$ _____	_____	_____	<input type="checkbox"/> Other (Indiv. or Group)*	\$ _____	_____	_____
<input type="checkbox"/> State Disability	\$ _____	_____	_____	<input type="checkbox"/> Auto Ins. Wage Replacement*	\$ _____	_____	_____
<input type="checkbox"/> Canadian Pension Plan	\$ _____	_____	_____	*If yes, give name and address of Insurer below			

Insurer Name(s)	Address
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22 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	23 If married, spouse's name and Social Security No.	24 Spouse Date of Birth
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25 Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	26 List Children under age 25 (Names and Dates of Birth)
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27 If benefits are approved, do you want the minimum \$20.00 per week withheld from your check for Federal Income Tax purposes? Yes No
 If you want more withheld, please state dollar amount you want withheld \$ _____

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Signature X _____ Date _____

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
 Write "NA" in non-applicable sections.

1 Employee's Name		2 Social Security No.	
Street/Box/Apt.		3 Date of Birth	
City, State, Zip		4 Regularly Scheduled Hours Per Week	
5 Date of Hire	6 Employee's STD Effective Date	7 Employee's LTD Effective Date	8 Occupation
9 Policy No.	10 Policy Division No.		11 Policy Class
12 Employee's Work Schedule <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Seasonal			
13 Check Regular Workdays <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat			
14 If not at work when disability began, check status and provide date		15 How was employee paid? (check frequency and types)	
<input type="checkbox"/> Terminated <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other: _____ <input type="checkbox"/> Laid Off <input type="checkbox"/> Sick Leave _____ <input type="checkbox"/> Vacation <input type="checkbox"/> Resigned _____ Date _____		Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Type(s): <input type="checkbox"/> Hourly <input type="checkbox"/> Bonus <input type="checkbox"/> Salary <input type="checkbox"/> Commission	
16 Salary Prior to Date Last Worked		17 Date Last Salary Increase	19 New York DBL? <input type="checkbox"/> Yes
Base Weekly Wages \$ _____		18 Employee Work Schedule at Time Last Worked _____ Days per week _____ Hours per week	New Jersey TDB? <input type="checkbox"/> Yes
W-2 Earnings \$ _____			(If yes, complete reverse side)
Overtime \$ _____			
Commissions \$ _____			
Bonus \$ _____			
20 Date Last Worked	21 Hours Worked That Day	22 Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
23 Date Paid Through _____ For <input type="checkbox"/> Salary Continuation <input type="checkbox"/> Vacation <input type="checkbox"/> Accrued Sick Pay			
24 Does employee contribute toward the STD premium? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax If Post Tax, _____ % paid by employer _____ % paid by employee			
25 Does employee contribute toward the LTD premium? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax If Post Tax, _____ % paid by employer _____ % paid by employee			
26 Employee is Eligible for:	Yes No	If yes, Weekly or Monthly Amount	Wk Mo Provider Name/Address Date Benefits Begin Through
Salary Continuation	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
Disability Pension	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
Retirement Pension	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
State Disability	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
Unemployment	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
Social Security	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
Workers' Compensation	<input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> _____
Has Workers' Comp. claim been filed?	<input type="checkbox"/> <input type="checkbox"/>	If Workers' Compensation has been denied, submit copy of denial with this claim.	
27 Does your company have a rehire or return to work policy for disabled employees? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the name of the person we should contact if we identify a return to work option?			
28 Name/Address of the employee's medical insurance carrier or HMO (provide policy or ID No.)			
29 Employer's Name		Phone No. ()	
Street Address	City	State	Zip
Signature (The above statements are true and complete to the best of my knowledge) X		Date	

A Job Description is required if employee is out of work more than 6 weeks.

Section 3: To Be Completed By Employer

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.

Complete this side if the employee is eligible to receive New York (DBL), or New Jersey (TDB).

Employee Name	Social Security No.	Weekly Wages Last Day Worked \$ _____
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In the following spaces show dates and claimant's GROSS earnings in New York and/or New Jersey employment during the last weeks prior to the week disability began.

	Calendar Week End Date	Gross Wages
Calendar Week in Which Disability Began	_____	\$ _____
Prior Week Before Disability	_____	\$ _____
2nd Week Before Disability	_____	\$ _____
3rd Week Before Disability	_____	\$ _____
4th Week Before Disability	_____	\$ _____
5th Week Before Disability	_____	\$ _____
6th Week Before Disability	_____	\$ _____
7th Week Before Disability	_____	\$ _____
8th Week Before Disability	_____	\$ _____
	Total	\$ _____

Section 4: To Be Completed By Physician

Patient Name	Date of Birth	Social Security No.
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Height	Weight	Blood Pressure (last visit)
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1 Patient is/was unable to work due to: (check one) Injury Illness Pregnancy

2 Diagnosis (include complications and ICD 9)

For Normal Pregnancy, complete items 3-6, then skip to item 25

3 What was LMP date?	4 What is the expected date of delivery?	5 Date First Treated	6 Date Last Treated
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For all conditions except Normal Pregnancy, complete the following items

7 When did symptoms first appear or accident happen?	8 Date you advised patient to stop working	9 Is condition due to injury or illness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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10 Has patient ever had same or similar condition? Yes No
 If yes, state when and describe

11 Date of First Visit	12 Date Last Visit	13 Frequency of Visits
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14 Objective Findings (X-rays, EKG's, lab data and clinical findings)	15 Subjective Symptoms
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16 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency

17 Names and addresses of other physicians

18 Has patient been hospitalized? Yes No If Yes, give name and address
 From _____ to _____

19 Restrictions (what the patient SHOULD NOT do)	20 Limitations (what the patient CANNOT do)
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21 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis

I	IV
II	V
III	

22 If this is a cardiac condition, what is the functional capacity? (American Heart Association)

<input type="checkbox"/> Class 1 - No Limitation	<input type="checkbox"/> Class 3 - Marked Limitation
<input type="checkbox"/> Class 2 - Slight Limitation	<input type="checkbox"/> Class 4 - Complete Limitation

23 Has maximum medical improvement been achieved? Yes No
 If no, when do you expect a fundamental change?
 1-2 weeks 3-4 weeks 5-6 weeks More than 6 weeks

24 If employer can accommodate patient's limitations and restrictions, is patient able to return to work? Yes No
 If yes, what date could employment begin?

25 Physician Name (Please Print) Degree

Specialty	Phone No.	Fax No.
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Address	City	State	Zip
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Signature (No Stamp)	Tax ID No.	Date
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X