Harleysville Life Insurance Company

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

Section I **Employer's Statement** - to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section J).

Section II **Employee's Statement -** to be completed by the employee who is applying for Long Term Disability benefits. Please attach a copy of the employee's driver's license.

Section III **Authorization to Obtain Information** - to be signed by the employee.

Section IV **Attending Physician's Statement** - to be completed by the physician who is treating the employee.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO : Disability RMS
One Riverfront Plaza
Westbrook, Maine 04092-9700

For service regarding your Long Term Disability claim call 1-866-537-7631

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS
HARLEYSVILLE LIFE INSURANCE COMPANY

Section I
Employer's Statement

To be Completed by the Employer

This claim is for ***(Employee's Name)***	Social Security Number	Date of Birth

Employee's Address *(Street, City, State, Zip)*

A. Information About the Employer

Company's Name	Group Policy Number
Address *(Street, City, State, Zip)*	Telephone Number
Name and address of division where employee works *(if different from above)*	Fax Number

B. Information About the Employee

Date employee was hired	Date employee became insured under this plan	What was the employee's regularly scheduled work week? ___ hours per week

Was the employee's LTD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "yes," attach copy.

Was the employee insured under your prior LTD Policy? ☐ Yes ☐ No
If "Yes," please provide the inclusive date of coverage. From ______________________ Through __________________

Has the employee been terminated? ☐ Yes ☐ No If "Yes," date: ____________________
Reason:

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No
Did LTD insurance continue while on Family Leave? ☐ Yes ☐ No
Date Leave of Absence started under Family Leave Act ____________________________

C. Information Needed for Withholding and Reporting Taxes

PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD LONG-TERM DISABILITY PREMIUM (See Internal Revenue Code Section 105(a) and Regulations thereunder) ____________% OF EMPLOYEE CONTRIBUTION	EMPLOYEE'S CONTRIBUTION WERE MADE ON: ☐Pre-or ☐ Post-tax basis	PREMIUM PAID THRU DATE

D. Information About the Claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became totally disabled?
☐ Yes ☐ No If "Yes," what were the changes, and when were they made?

What was the employee's permanent job on his or her last day at work?	How long had this employee been in this job?

Last day employee actually worked	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _______________

Why did the employee stop working?	Is the employee's condition work related? ☐ Yes ☐ No
Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury and award notice.	Date employee is expected/did return to work _____________ Full time? ☐ Yes ☐ No (Month, Day, Year)

Name and address of your compensation carrier

E. Information About Your Pension Plan (*Do not complete for maternity claim)*

Do you have a pension plan? ☐ Yes ☐ No	If "Yes," what type? (*Check as many as applicable)*	☐Defined benefit ☐ 401 K ☐ Other (Specify) ☐ Defined contribution ☐ Profit Sharing

Is the employee eligible for your pension plan? ☐ Yes ☐ No If "No," why?	If eligible, does the employee participate? ☐ Yes ☐ No If "No," why?

If the employee is participating, when is he or she eligible for benefits under the plan? ______________________
(Month, Day, Year)

At what point does the employee qualify for a full pension? ______________________________________
Is there a Disability Retirement Option available to this employee? ☐ Yes ☐ No

F. Information About Your Rehire Return-to-Work Policies

Does your company have a rehire or return–to-work policy for disabled employees? ☐ Yes ☐ No

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

G. Information About the Employee's Salary

Basic Salary or wage immediately prior to cessation of work because of disability (exclude bonuses, overtime, pay, etc.) $ ___ ☐ Monthly ☐ Weekly ☐ Annually ☐ Hourly # Hours/Week ______________________________

Is this employee eligible for salary continuation?
☐ Yes ☐ No If "Yes," what is the weekly amount? $ _______________ When do benefits begin? ____________ End?____________

Will the employee file for Short Term or State Disability benefits?
☐ Yes ☐ No If "Yes," what is the weekly amount? $ _______________ When do benefits begin? ____________ End?____________

List any other sources of income to which the employee is entitled as a result of this disability:

H. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time

	Frequency of Occurrence			
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	____________________	____________	_____ **lbs.**
☐ Pulling	____________________	____________	_____ **lbs.**
☐ Lifting	____________________	____________	_____ **lbs.**
☐ Carrying	____________________	____________	_____ **lbs**.

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

____ _____ %
____ _____ %
____ _____ %

I. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily of permanently? ☐ Yes ☐ No
If "Yes," explain.

Is it possible to offer the employee assistance in doing the job (**e.g., through the use of technology or personal assistance)**
☐ Yes ☐ No If "Yes," explain.

J. Required Attachments and Signature

Please attach a copy of the employee's job description.
If the employee contributes to the premiums, attach a copy of the enrollment form and/or copies of the last two Flexible Benefits Election Forms.
If salary is based on a W-2, K-1, 1099, or a similar document, attach a copy of the document,
If you have medical information from the employee's file relating to this disability, please attach copies.
If a Workers' Compensation claim is filed, send initial report of injury or illness and award notice.
Name of person completing this form (if this claim is approved for disability benefits, the benefit check will be sent to the employee with a copy to you).

Unless you reside in Virginia, the following general fraud notice applies: 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.
I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

______________________________ ______________________________
Name (Please print or type) Title

______________________________ ______________________________
Signature Date

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS
HARLEYSVILLE LIFE INSURANCE COMPANY

Section II
Employee's Statement

To be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS – FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information about you

Last name | First | Middle Initial

Address (*Street*) | City | State/Province | Zip

Telephone Number

Date of Bir6th (*Month, Day, Year)*	Height	Weight	☐ Male ☐ Female	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Your employer *(include division, if applicable)* | Occupation

When you disability began, did you have more than one employer? ☐ Yes ☐ No. If "Yes," please provide the name, address, and phone number of that employer, and indicate the dates when you worked.

Please indicate the extent of you formal education *(Circle one)*

High School: 1 2 3 4 5 6 7 8 9 10 11 12
College 1 2 3 4 Masters ____________ Ph.D. ____________

Trade School: ____________

Briefly describe your past work experience for the last 20 years *(Begin with you most recent job.)*

Job Title	Duties	Years Worked
(a)		
(b)		
(c)		
(d)		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work?
☐ Yes ☐ No

Have you contacted your State Department of Vocational Rehabilitation?
☐ Yes ☐ No If "Yes," please include the name, address, and telephone number of your counselor.

B. Information About your Family *(Required to determine your eligibility for Social Security Benefits)*

Spouse's Name *(Last, first)*

Spouse's Social Security Number	Date of Birth *(Month, Day, Year)*	Is your spouse employed? ☐ Yes ☐ No	Retired? ☐ Yes ☐ No

Do you have any children under age 19?
☐ Yes ☐ No If "Yes," name and date of birth of your youngest child

Do you have any children with disabilities *(regardless of age)?*
☐ Yes ☐ No If "Yes," name and date of birth of each child

HARLEYSVILLE LIFE INSURANCE COMPANY
APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

C. Information About the Condition Causing Your Disability

1. For illness, answer the following questions:

What were your first symptoms?

When did you first notice them?	Have you had this illness before? If so, when?

2. For an injury, answer the following questions:

When, where and how did the injury occur?

3. For Illness, Injury or Pregnancy, answer the following questions:

Date you were first treated by a physician? ______ (Month Day Year)	Name of Physician ______ Address of Physician ______

Before you stopped working, did your condition require you to change your job, or the way you did your job?
☐ Yes ☐ No If "Yes," explain.

What aspect of your condition made you unable to work?

Is you condition related to your occupation?
☐ Yes ☐ No If "Yes," explain.

Have you filed, of do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

D. Information About the Disability

Last day you worked before the disability ______ (Month Day Year)	Did you work a full Day? ☐ Yes ☐ No If "No," explain.	Date you were first unable to work ______ (Month Day Year)

Date you returned to Work on a part-time basis: / /	Date you returned to Work on a full-time basis: / /
Since that date, have you done any work? ☐ Yes ☐ No If "Yes," please indicate dates worked, name of employer, and amount earned.	If you have not returned to work, do you expect to? ☐ Yes Part time (date) ______ Full Time (date) ______ ☐ No

E. Information About Physicians and Hospitals

First medical attention for the current disability was given by (complete below)

Doctor's Name	Telephone FAX: ( )	Specialty
Address *(Street, City, State, Zip)*		Dates seen **to**

List all Physicians and Hospitals you have seen for this condition (attach separate sheet, if needed)

Doctor's Name	Telephone FAX: ( )	Specialty
Address *(Street, City, State, Zip)*		Dates seen **to**
Hospital		
Address *(Street, City, State, Zip)*		Dates of Confinement **to**

Have you consulted any other physicians or been hospitalized in the past three years? ☐ Yes ☐ No
If "Yes," complete the following concerning your past treatment (Attach separate sheet, if needed)

Doctor's Name	Telephone FAX: ( )	Specialty
Address *(Street, City, State, Zip)*		Dates seen **to**
Hospital		
Address *(Street, City, State, Zip)*		Dates of Confinement **to**

F. Other Income

Check the other income benefits you have received/are receiving , or are eligible to receive during you disability (complete the information requested)

Source of Income	Amount (week/month)	Date Claim was filed	Date Payments began	Date Payments ended
Social Security/Retirement	$____/_______	__________________	____________________	___________________
Social Security/Disability	$____/_______	__________________	____________________	___________________
Sick pay or Salary Continuation	$____/_______	__________________	____________________	___________________
Income from Work	$____/_______	__________________	____________________	___________________
Workers' Compensation	$____/_______	__________________	____________________	___________________
State Disability	$____/_______	__________________	____________________	___________________
Pension/Retirement	$____/_______	__________________	____________________	___________________
Pension/Disability	$____/_______	__________________	____________________	___________________
Short Term Disability	$____/_______	__________________	____________________	___________________
Unemployment	$____/_______	__________________	____________________	___________________
No-Fault Insurance	$____/_______	__________________	____________________	___________________
Other (Include individual or Group Benefits)	$____/_______	__________________	____________________	___________________

G. Information about Tax Withholding

Federal law requires us to withhold federal income tax from your check **if you request us to do so.** We are also required to send a report to you employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and you social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $87.00 per month): $ ___________.00.

H. Signature

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my Harleysville Disability Income. Further, I understand that should I receive income of any kind of perform work of any kind during any period Harleysville Life has approved my disability claim, I must report all details of Harleysville Life, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all state EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, and Virginia: 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 substantial civil penalty where and to the extent of the law.

For residents of Florida: Subject to Section 817.234(b): "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 residents of New Jersey: Subject to Section 17:33 a-6(a): "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties."

For residents of Colorado: Subject to Section 10-1-127(7)(a): "It is unlawful to knowingly provide false, incomplete, or misleading fact 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 of 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."

For residents of Pennsylvania: Subject to Section 4117: "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 a person to criminal and civil penalties."

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRED 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"

For residents of Arkansas: Subject to Section 23-66-503: "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."

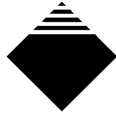
The statements contained in this application for Long Term disability Income Benefits are true and complete to the best of my knowledge and belief.

X ______________________________	**X** ______________________________
SIGNATURE OF THE EMPLOYEE	***DATE***

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

Disability RMS

Committed to a higher standard



AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA COMPLIANT)
(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, the Social Security Administration, 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 (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and Harleysville Life Insurance *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 Disability RMS, Harleysville Life Insurance Company 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 Disability RMS or Harleysville Life Insurance Company to assist with the evaluation and adjudication of my current disability claim and/or to report aggregate claims information to Harleysville Life Insurance Company. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. 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 Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or Harleysville Life Insurance Company 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 Disability RMS' and Harleysville Life Insurance Company's ability 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:** this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

If you reside in **Connecticut, Maine, or Massachusetts: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

***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 Disability RMS 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 Disability RMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: ___________________________________ Date of Birth: ___________________

Claimant Signature (or Authorized Representative) _________________________ Date: _____________

Description of Personal Representative's Authority (If applicable):
(*If signed by authorized representative, attach verification of identity)

HARLEYSVILLE LIFE INSURANCE COMPANY
APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section III

Authorization to Obtain and Release Non-Medical Information

TO: Any employer, group policyholder, contract holder or insurer, benefit plan administrator, Medical information Bureau, Inc., Heath Claims Index, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize you to release and send to: Harleysville Life Insurance Company or Harleysville Life Insurance Company representatives, a complete copy of any and all of the following information, records or documents relative to Harleysville Life Insurance Company

____ Insured's Name (*Please print.)*

____________________ (Date of Birth) ______________________________ (Social Security Number)

1. Work information and history, including, but not limited to, job duties, earnings, and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., bank records; business transactions of any kind or description, including billing, invoices or payment records of any kind; and academic transcripts.

2. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record.

I further authorize Harleysville Life Insurance Company or its reinsurers to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) on behalf of subscriber insurers. I understand that Harleysville Life Insurance Company may also send a brief report to HCI. An HCI report includes the dates of claims filed for or by me, claim date of loss and the names of companies to which claims were submitted, but does not contain medical information. Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by the Harleysville Life Insurance Company to any person or organization EXCEPT to reinsuring companies, The Index System, Medical Information Bureau, Heath Claim Index, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

I know that I may request to receive a copy of this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

____
Signature of Insured or Guardian

____
Relationship to Insured (*if signed by Guardian)*

____
Date

HARLEYSVILLE LIFE INSURANCE COMPANY **Section IV**

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

To be completed by the Employee

Name of patient ____________________________ Social Security Number_____________________ D.O.B. ____________________

Address of patient ____

Street *City* *State or Province* *Zip Code or Postal Code*

Employer's name *(and division, if applicable)* ____

____

I hereby authorize release of information on this form by the below named physician of the purpose of claim processing

Signed (Patient) ______________________________ Date __________

To be completed by the Attending Physician *(The patient is responsible for the completion of this form without expense to the Company).*

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy Height _____________ Weight _________

If pregnancy, what is the expected date of delivery? Month ________ Day________ Year ________

Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

DIAGNOSIS

Primary diagnosis: ____ ICD-9 Code: ________________

Secondary diagnosis(es): ____ ICD-9 Code(s): ______________

Subjective symptoms: ____

Test Results (list all results of enclose test):

Test: ______________________________________ Date: ______________ Results: ___________________________________

Test: ______________________________________ Date: ______________ Results: ___________________________________

Physical examination findings: ____

____

If pregnancy, indicate LMP date: Month ______________ Day ________________ Year________________

TREATMENTS

Date you first treated this patient: __________________________ Date you first treated this patient for this condition: _____________

Date of onset of this condition: ____________________________ Date of most recent treatment: ______________________

How often has patient been seen/treated?____ Date of next office visit: __________

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s): ____

Name and address: ____

____ Specialty: ______________________________

Nature of treatment for this condition: ____

____

Has surgery been performed? ☐ Yes ☐ No If "Yes," Date: ________________ Procedure: _______________ CPT Code: ________

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted: ________________ Date(s) Discharged ______

________________ ______

Name and address of hospital(s): ____

____

Progress *(Please check one):* ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

HARLEYSVILLE LIFE INSURANCE COMPANY
APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY *(Side two)*

IMPAIRMENT

If the patient's ability to perform any of the following activities is limited by his/her disorder, please indicate below.

Use these definitions for the frequency of occurrence:

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Frequency of Occurrence			
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping/Crouching	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Bending	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐
☐ Driving	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	______________________	__________	______ **lbs**
☐ Pulling	______________________	__________	______ **lbs**
☐ Lifting	______________________	__________	______ **lbs**
☐ Carrying	______________________	__________	______ **lbs**

If any other activities are limited, please specify the activities and the limitations: ______________________

If the patient's vision is impaired, please describe the extent of the impairment: ______________________

What is the psychiatric impairment?

- ☐ Inadequate information to make assessment.
- ☐ Essentially good functioning in all areas. Occupationally and socially effective.
- ☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- ☐ Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.
- ☐ Inability to function in almost all areas.

Date patient became unable to work due to this impairment? ______________________(Month, Day, Year)

If physical or psychiatric limitations exist, how long do you feel limitations will last? ______________________

Attending Physician Name: ______________________ Telephone #______________
(Please print or type.)

License No. ______________________ FAX # ______________

SS# or E.I.N.#: ______________________ Degree: __________ Specialty: ______________

Street Address: ______________________ City: __________ State: ________ Zip Code: ________

Signature: ______________________ Date signed: ______________