



Harleysville Life Insurance Company

APPLICATION FOR LIFE WAIVER OF PREMIUM BENEFITS

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

- Section I** **Employer's Statement (Group Life Waiver of Premium Claims ONLY)** – to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section I).
- Section II** **Claimant's Statement** – to be completed by the insured who is applying for Life Waiver of Premium benefits. Please attach a copy of your driver's license.
- Section III** **Authorization to Obtain Information** - to be signed by the claimant.
- Section IV** **Attending Physician's Statement** – to be completed by the physician who is treating the claimant.

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 Life Waiver of Premium claim call 1-866-537-7631.

APPLICATION FOR LIFE WAIVER OF PREMIUM
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
Did Group Life insurance continue while on disability leave? Yes No
Has the employee been terminated? Yes No If "Yes", date of termination: _____
Reason:
Has the employee been given notice of the right to convert group coverage to an individual plan of insurance? Yes No
If "Yes", date notice given: _____

C. 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?
What was the last day employee actually worked? Date employee is expected/did return to work
____ Full time? Yes No
(Month, Day, Year)
Why did the employee stop working?
Is the employee's condition work related? Yes No If "Yes", has a claim been filed with Workers' Compensation? Yes No
If "Yes", send initial report of illness or injury and award notice. Name and address of your workers' compensation carrier:

D. Information About Retirement Benefits

Is the employee currently receiving or applying for retirement benefits? Yes No Do you have a pension plan? Yes No If "Yes", is the employee eligible for your pension plan? Yes No
If "No", why?
Is there a Disability Retirement Option available to this employee? Yes No

E. 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?

F. 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

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

Can the job be modified to accommodate the disability either temporarily or 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.

COMPLETE REVERSE SIDE.

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.

Activity	Frequency of Occurrence			
	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping/Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____	_____	_____ lbs
<input type="checkbox"/> Pulling	_____	_____	_____ lbs
<input type="checkbox"/> Lifting	_____	_____	_____ lbs
<input type="checkbox"/> 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.

_____	_____ %
_____	_____ %
_____	_____ %

DATE RETURNED TO WORK / / <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK _____	IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE: / /
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I. Required Attachments and Signature

Please attach a copy of the employee's job description.

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, correspondence will be sent to the employee with a copy to you).

The statements contained in this application for Life Waiver of Premium Benefits are true and complete to the best of my knowledge and belief.

Name (Please print or type)

Title

Signature

Date

PLEASE MAIL COMPLETED AND SIGNED FORM TO:

Disability RMS
 One Riverfront Plaza
 Westbrook, Maine 04092-9700

For questions regarding completion of this form, please call 1-866-537-7631

HARLEYSVILLE LIFE INSURANCE COMPANY

Claimant's Statement

To be Completed by the Insured/Claimant (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 Birth (Month, Day, Year) _____ Height _____ Weight _____ Male Female

Your employer (include division, if applicable) _____ Occupation _____

When your 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.

Are you currently working in any capacity, at any occupation? Yes No
If "Yes", please provide details:

Are you currently receiving, or have you filed, for Social Security Retirement, Pension Retirement or any other retirement benefits? Yes No

Please indicate the extent of your 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 your 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 name, address, and telephone number of your counselor.

B. 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? _____ Name of Physician _____
(Month, Day, Year) _____ 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 your condition related to your occupation?
 Yes No If "Yes", explain.

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

C. Information About the Disability

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

Since that date, have you done any work? Yes No If you have not returned to work, do you expect to?
If "Yes", please indicate dates worked, name of employer, and amount earned. Yes Part Time (date) _____ Full Time (date) _____
 No

D. Information About Physicians and Hospitals

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

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

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

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

Hospital _____
Address (Street, City, State, Zip) _____ Dates of Confinement _____
to _____

DATE RETURNED TO WORK / / <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK	IF YOU HAVE NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE: / /
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E. Signature

I certify by my signature that I have not received or applied for any source of retirement income. Further, I understand that should I receive or apply for retirement income of any kind or perform work of any kind during any period Harleysville Life has approved my waiver of premium claim, I must report all details to Harleysville Life, immediately.

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 Life Waiver of Premium Benefits are true and complete to the best of my knowledge and belief.

X _____
SIGNATURE OF THE INSURED

X _____
DATE

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

APPLICATION FOR LIFE WAIVER OF PREMIUM

Section III

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)

PLEASE MAIL COMPLETED AND SIGNED FORM TO:
Disability RMS
One Riverfront Plaza
Westbrook, Maine 04092-9700

For questions regarding completion of this form, please call 1-866-537-7631

APPLICATION FOR LIFE WAIVER OF PREMIUM
HARLEYSVILLE LIFE INSURANCE COMPANY

Section IV

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

To be completed by the Claimant

Name of patient _____ Social Security Number _____ DOB _____

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 _____ Signed (Patient)
named physician for the purpose of claim processing _____ 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 Height _____ Weight _____

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 enclosed tests):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Physical examination findings: _____

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

**APPLICATION FOR LIFE WAIVER OF PREMIUM
HARLEYSVILLE LIFE INSURANCE COMPANY**

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.

Activity	N/A	Frequency of Occurrence		
		Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping/Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____	_____	_____ lbs
<input type="checkbox"/> Pulling	_____	_____	_____ lbs
<input type="checkbox"/> Lifting	_____	_____	_____ lbs
<input type="checkbox"/> 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? _____

RETURN TO WORK PLAN	Have you discussed a return to work plan with your patient? <input type="radio"/> Yes <input type="radio"/> No	The date you released patient to return to work: ____/____/____ <input type="radio"/> Full-time <input type="radio"/> Reduced hours Number of hours: _____
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Please identify your recommendations for any job modifications that would enable the patient to work.

Attending Physician Name: _____ Telephone Number: _____
(please print or type)

License No. _____ Fax Number _____

SS# or E.I.N.#: _____ Degree: _____ Specialty: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Signature: _____ Date signed: _____

PLEASE MAIL COMPLETED AND SIGNED FORM TO:
Disability RMS

One Riverfront Plaza
Westbrook, Maine 04092-9700