ABACUS SERIES™

Issued through KANSAS CITY LIFE INSURANCE COMPANY

Hospital Indemnity/Injury and Disability Income Claim Form

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

Section I **Employer's Statement** - to be completed by the **employer's** authorized representative.

Section II **Employee's Statement** - to be completed by the **employee** who is applying for Hospital Indemnity.

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.**

Attach copies of the following - UB-92 forms (hospital bills), HCFA forms (Physician bills) or itemized bills that provide Dates of Service, Type of Service, Diagnosis and charges. The actual UB-92 and HCFA forms will allow for the quickest processing. You can ask your Doctor and/or hospital to provide these to you.

Mail all completed forms and documents to:

ABACUS Series
Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530

* If you elected Short Term Disability through Abacus Series and are also filing a Short Term Disability claim, consider completing form LC-5180-20 instead to expedite your claim process.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR ABACUS BENEFIT MANAGEMENT SERVICE CENTER.

Hospital Indemnity/Injury and Disability Income Claim Form

To Be Completed by the Employee

This claim is for (Employee's Name)	Social Security Number	Date of Birth
Employee's Address (Street, City, State, Zip)		
Occupation	Date of Hire	Employee's Phone Number

Claim Information

1. Claim is for: ❑ Accident ❑ Illness Nature of Accident/Injury: _____

2. Date you were first treated by a physician _____
(Month / Day / Year)

3. Has claim been made or will claim be made under any Worker's Compensation or Employers Liability Law? ❑ Yes ❑ No

4. Were you Hospitalized? ❑ Yes ❑ No If "Yes", give dates, from _____ to _____
(Month / Day / Year) (Month / Day / Year)

Name/Address of Hospital _____
If you were hospitalized, please send a copy of the hospital bill.

5. List all Doctors you have seen for this condition.

Name	Address	Date 1st seen

6. Have you ever had symptoms of this condition before? ❑ Yes ❑ No If "Yes", when? _____

Information About Tax Withholding

Federal law may require us to withhold federal income tax from your taxable benefit check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you wants us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $20.00 per payment). $_____. **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check.

Claimant Signature _____ **Date** _____

To be completed by the Employer

Company's Name	Group Policy Number	Employer's Phone Number
Employer's Address / Division Where Employee Works(Street, City, State, Zip)		
Date Employee was hired.	What was the employee's regularly scheduled work week? Hours per Week _____	Date employee became insured under this plan.

Schedule workdays M - F _____ Other _____

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Information Needed for Withholding and Reporting Taxes

What percentage of the benefit is taxable? _____ %.
What percentage, if any, do you contribute towards the cost of the premium? _____ %.
Does the employee contribute towards the cost of the premium? ❑ Yes ❑ No. If "Yes", at what percentage? _____ %.
Is it on a ____ Pre or _____ Post-tax basis? What percent of this employee's benefits is taxable? _____ %.

Information About the Claim

Is the employee's condition work related? ❑ Yes ❑ No.
Has the claim been filed with Worker's Compensation? ❑ Yes ❑ No. If "Yes", send initial report of illness or injury or award notice.

Signature

Employer's Name	Title
Employer's Signature	Date
Area Code Telephone Number	Area Code Fax Number

Signature

With the exception of any source(s) of income reported above in Section D of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my Abacus Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period Abacus has approved my disability claim, I must report all details to Abacus, 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 states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia and Puerto Rico: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) Abacus shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of 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.

For residents of New Jersey, Arkansas, and New Mexico: 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 an insurance policy is subject to criminal and civil penalties.

For residents of Pennsylvania: 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 Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES 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 Louisiana: 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.

For residents of New York: 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 residents of Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

X _____ **X** _____

Signature of the Employee | Date

ABACUS SERIES
Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

Authorization to Obtain and Release Information

Section III

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to Abacus Series a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 5 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Abacus Series.

I ALSO UNDERSTAND that once My Information has been disclosed to Abacus Series, as permitted under this Authorization, it may be re-disclosed by Abacus Series as permitted by law or my further authorization. I authorize Abacus Series to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Abacus Series may make unless Abacus Series has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Abacus Series. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Abacus Series to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian	Relationship to Insured (*if signed by Guardian*)	Date

ABACUS SERIES™ Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

Attending Physician's Statement of Disability
To be completed by the Attending Physician
Section IV

Name of patient	Social Security Number	Date of Birth	Height	Weight

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy If pregnancy, expected date of delivery? _____

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

DIAGNOSIS

Primary diagnosis: | ICD-9 Code:

Subjective symptoms:

Physical examination findings: List all test results,or enclose test:

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Blood Pressure (Systolic) _____ Diastolic _____ Date _____

Remarks:

TREATMENTS

Date of onset of this condition _____ Date of next office visit: _____

List all dates of treatment for this condition since patient ceased working

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

Name _____ Address: _____ Specialty: _____

Nature of treatment for this condition: _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If Yes, Name of hospital _____

Dates admitted _____ Dates discharged _____

Has surgery been performed? ☐ Yes ☐ No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

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

IMPAIRMENT

What are the current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity
(Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
(Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment (*if applicable)?*

☐ 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.

☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.

☐ Major impairment in several areas - work, family relations. Avoidant behavior, neglects family, is unable to work.

☐ Inability to function in almost all areas.

Attending Physician's Name _____ Social Security Number or E.I.N. # _____

Telephone Number: (___) _____ Fax Number: (___) _____ Degree _____ Specialty _____

Address _____

Signature _____ Date Signed _____