Underwritten by: Madison National Life Insurance Company, Inc.
Administered by: North American Benefits Company

Mail to:
North American Benefits Company
P.O. Box 3056
Southeastern, PA 19398-3056
1.800.346.7813

EMPLOYER'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurance provider, we are committed to assisting your employee in a return to productive employment. Please complete the following information thoroughly, as this will allow us to accurately evaluate this claim and assist your employee with a successful return to work. An incomplete claim form will not be accepted.

Employee's name:_____ Social security number: _____

Address:_____
Street City State Zip Code

Telephone number:_____ Date of Birth:_____

EMPLOYEE INFORMATION

Employee's date of hire:_____ Date employee became insured for benefits: _____

What was the employee's permanent job on his or her last day of work? _____

How long had the employee been in this job?_____ Last date employee actually worked:_____

On the last day worked did the employee work a full day? ☐ Yes ☐ No If no, how many hours were worked? _____

Why did your employee stop working? _____

_____

_____

Were there any changes to your employee's job responsibilities prior to the last day of work?

☐ No ☐ Yes If yes, what were the changes and when were they made?_____

_____

What is your employee's regularly scheduled work week? _____Hours per week. _____Hours per day. Hourly wage if applicable:_____

What was your employee's Basic **ANNUAL** Salary as of his/her last day of work? $_____

Has your employee returned to work? ☐ No ☐ Yes If yes, Part-time date:_____Full-time date:_____

If employee returned to work, he / she returned: ☐ At full capacity ☐ With work restrictions. If the employee returned with restrictions, please indicate the specific restrictions: _____

_____

SALARY / OTHER INCOME / TAX INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ **Short Term Disability benefits** ☐ **Long Term Disability benefits** ☐ **Life Insurance Waiver of Premium benefits**

If claim is for Life Insurance Waiver of Premium benefits, please indicate:
Effective date of coverage**:**_____Basic Coverage Amount: $_____
Supplemental Coverage Amount: $_____Total Number of dependents:_____spouse_____children

How many contract days does this employee work:_____ Total number of sick days employee has:_____

If your employee worked based on contracted days, please provide a calendar documenting each contract day.

CONTINUED ON REVERSE SIDE

Name of Employee:_____ **Date of Birth**_____

SALARY / OTHER INCOME / TAX INFORMATION CONTINUED

Has your employee received or will he/she receive any pay from the following: ☐ Salary continuance ☐ Sabbatical Pay ☐ Sick Leave

If you checked any of the above please complete the following:

The employee received pay from _____ to _____ in the amount of $_____ per ☐ Week ☐ Month.

Is the employee's disabling condition work-related? ☐ No ☐ Yes ☐ Unknown

Has a claim been filed with Workers' Compensation? ☐ No ☐ Yes ☐ Unknown

If yes, what is the current status of the Workers' Compensation claim? ☐ Approved ☐ Denied ☐ Currently Disputed

Please send any Worker's Compensation claim information that you may have including benefit payment information if applicable.

If this is an STD claim, does the employee pay any of the STD insurance premium? ☐ No ☐ Yes If yes, the contribution is: ☐ Pre-tax ☐ Post-tax

If "Post-tax", _____% paid by employer _____% paid by employee. $_____ employer, $_____ employee

If this is an LTD claim, does the employee pay any of the LTD insurance premium? ☐ No ☐ Yes If yes, the contribution is: ☐ Pre-tax ☐ Post-tax

If "Post-tax", _____% paid by employer _____% paid by employee. $_____ employer, $_____ employee

(Note: If employee paid disability premium is pre-tax, we will deduct FICA tax as if the employer was paying 100% of the disability premium.)

To the best of your knowledge, is your employee receiving, or entitled to receive benefits from any of the following as a result of this disability:

☐ Social Security ☐ Other Government Agency ☐ Teachers or Public Employees' Retirement System
☐ Statutory Disability Income, e.g. Workers' Compensation ☐ Any other Disability or Retirement Plan (Employer-sponsored or not)

FOR ANY YES ANSWER PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name and address of carrier or administrator:_____ Telephone Number:_____

RETURN TO WORK CONSIDERATIONS (Complete if employee has not yet returned to work)

Does your company/organization have a return-to-work policy for disabled employees? ☐ No ☐ Yes

Do you, or does someone from your company/organization, maintain contact with your employee? ☐ No ☐ Yes Frequency? _____

Can you provide transitional job duties for your employee to allow a gradual return to work? ☐ No ☐ Yes

Has this information been communicated to your employee's physician? ☐ No ☐ Yes

Have you discussed a return to work with your employee? ☐ No ☐ Yes What is the anticipated return to work date? _____

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

_____

Name Title Telephone Number

Would you like a Vocational Rehabilitation Case Manager to assist your employee in the return to work process? ☐ No ☐ Yes

Do you have any other comments which might help us better manage this claim? _____

_____

PLEASE ATTACH A JOB DESCRIPTION OUTLINING THE JOB DUTIES AND PHYSICAL DEMANDS OF THIS EMPLOYEE'S OCCUPATION

CONTACT INFORMATION

Employer's Group Name:_____ Group/Policy number: _____

Mailing address:_____

Street City State Zip Code

Name and title of individual completing this form (please print): _____

Telephone number:_____ Fax number: _____

Email address: _____

I have received and read the fraud warning statements provided with this form.

Signature_____ **Date** _____

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EMPLOYEE'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurer we are committed to assisting you in a return to health and to productive employment. Please complete the following form as thoroughly as possible. By accepting forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights and / or defenses. Any incomplete claim form will not be accepted. **We highly recommend that you also provide medical records from each of your treating physicians to help expedite the review of your claim.** Lack of medical records may result in a delay in the review of your claim.

BACKGROUND INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ **Short Term Disability benefits** ☐ **Long Term Disability benefits** ☐ **Life Insurance Waiver of Premium benefits**

Name (print): _____ Social security number: _____

Address: _____ Telephone number: _____

City: _____ State: _____ Zip: _____ Email address: _____

Date of birth: _____ ☐ Male ☐ Female Height: _____ Weight: _____ ☐ Single ☐ Married

Name and birth date of spouse and all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school or (3) disabled children regardless of age if their disability began before age 22):

_____

_____

Your employer's name: _____ Occupation/Job title: _____

Date of hire: _____ Annual salary: _____

Please indicate the extent of your formal education (*circle one*)

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

If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*):

Job title, Employer, City and State	Duties:	Dates worked:
(a)		
(b)		
(c)		
(d)		

CLAIM INFORMATION

Is your claim related to an accident or injury? ☐ No ☐ Yes If yes, date and time of accident or injury: _____

Describe how and where the accident or injury occurred: _____

_____

Is your claim related to your occupation? ☐ No ☐ Yes If yes, have you filed a Worker's Compensation claim? ☐ No ☐ Yes

If you have filed a Workers' Compensation Claim, please indicate the status of your claim as well as your weekly benefit amount if your claim has been approved: _____

If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation Services? ☐ No ☐ Yes ☐ My Workers' Compensation claim is currently being disputed

Is your claim related to an illness ☐ No ☐ Yes If yes, Date symptoms first appeared: _____

Please list all symptoms associated with your claim: _____

_____

Date you ceased work: _____ Have you returned to work? ☐ No ☐ Yes If yes, date returned: _____ ☐ Full-time ☐ Part-time

If you have returned to work part time please indicate the number of hours: _____ per day _____ days per week

Continued on Reverse Side

Name_____ DOB#_____

CLAIM INFORMATION CONTINUED

When do you plan to return to your job either on a full-time or part-time basis? Please explain in detail: _____

Please describe the primary tasks of your occupation: _____

Has your doctor provided work restrictions? ☐ No ☐ Yes If yes, please describe: _____

Can you return to your job or another job with your current employer if accommodations were made? ☐ No ☐ Yes If yes, please describe the accommodation needs: _____

Are there any concerns you have about returning to work? ☐ No ☐ Yes If yes, please describe: _____

MEDICAL INFORMATION

Please provide us with a brief description of your condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work: _____

Date first treated for this condition: _____ Name of physician that provided initial treatment: _____

Have you ever had the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of doctor:

Name Street Address

City State Zip Phone

Have you ever been hospitalized for the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of hospital:

Name Street Address

City State Zip Phone

If claim is related to Pregnancy: Expected date of delivery:_____ Actual Date of Delivery:_____ ☐Vaginal ☐C-Section

Were / are there any complications associated with your pregnancy? ☐ No ☐ Yes If yes, please describe: _____

OTHER INCOME BENEFITS / FEDERAL TAXES

Your monthly benefit may be affected by other income benefits received. We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ No	☐ Yes	Social Security Disability or Retirement	☐ No	☐ Yes	Unemployment Benefits	☐ No	☐ Yes
Vacation/Bonus Pay	☐ No	☐ Yes	Retirement Benefits	☐ No	☐ Yes	Other Income Benefits	☐ No	☐ Yes
Automobile No-Fault	☐ No	☐ Yes	Short Term Disability	☐ No	☐ Yes	Workers' Compensation	☐ No	☐ Yes

If you have been awarded any of the above other income benefits, please list the type of benefit, benefit amount, frequency of payment, and benefit effective date:

Have you tried any type of other work since the date your ceased work, as noted above? (either for this employer, another employer or through self-employment) ☐ No ☐ Yes if yes, provide name and address of employer, type of work, when employment began and number of hours worked per week: _____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature _____ **Date**_____

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REIMBURSEMENT AGREEMENT
GROUP DISABILITY INSURANCE BENEFIT
(Please read carefully)

When Madison National Life Insurance Company, Inc. ("MNL") has made benefit payments to you in excess of the amount required by the provisions of this policy, or during periods of time for which you subsequently receive retroactive benefits from any source that may offset your benefits under the group policy, you must, in a timely manner, reimburse MNL for such payments, including duplicate or erroneous payments. In addition and upon request, you must execute and deliver to MNL such documents as may be required and do whatever else is necessary to secure our rights to recover any excess, duplicate, or erroneous payments. Such reimbursement will be due and payable immediately upon our notification to and demand of you. Or, at our option, the subsequent payment of benefits or the refund of any premium owed you by MNL may be reduced or refused as a setoff and applied toward such reimbursement. If you delay in notifying MNL of your receipt of a reimbursable income benefit or in making reimbursement to MNL, MNL will have the right to charge interest at a reasonable rate on the delinquent amount owed to MNL. Our acceptance of premium and other fees, or our providing or paying disability benefits, does not constitute a waiver of our right to enforce the provisions of this agreement and/or the group policy in the future. The provisions of this agreement are in addition to, and not in lieu of, any other rights or remedies available to MNL at law or in equity.

Agreement

If my application for group disability insurance benefits is approved, in consideration of the payment of benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described and provided for in the group policy, I hereby agree to reimburse Madison National Life Insurance Company, Inc. for any and all overpayments made to me under the group disability plan provided by employer. I understand that MNL agrees to make payment in this manner in consideration of my agreement to promptly notify MNL of the amounts and effective dates of any such benefits. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators or assigns under the applicable group policy may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the applicable policy.

With respect to any group life insurance coverage provided me by MNL and in consideration of the foregoing, I hereby assign to MNL, as creditor beneficiary, an amount of such group life insurance equal to the amount of any overpayment which may be outstanding under any applicable group disability policy at the time of death.

In witness of the above, the parties hereto have caused this Agreement to be executed, as of the date indicated.

At _____, _____, this _____day of_____, 20_____
(City of Residence) (State of Residence)

_____
Printed Name of Claimant

_____
Signature of Claimant

_____
Signature of Spouse

_____
Witness (must be over age 18)

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Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance Company, or its legal representative, may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): _____ **Date of birth:** _____ **Telephone number:** _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company, or its legal representative, for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

to: **Madison National Life Insurance Company (address, telephone and fax number documented above)**

This form serves as an authorization for Madison National Life Insurance Company, or its legal representative, to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2009 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2009 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance Company, or its legal representative, the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance Company, or its legal representatives, for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance Company, or its legal representative, may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance Company, or its legal representative, may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance Company, or its legal representative, at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance Company, or its legal representative, may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company, or its legal representative, the protected health information described in this form.

Signature _____ **Date** _____

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ACTIVITIES OF DAILY LIVING

Notice to all persons completing this questionnaire: It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result from such an act.

Name (please print): _____ **Claim number:** _____

Address: _____

Telephone number: _____ **E-mail address:** _____

GENERAL INFORMATION

Please describe your ***current*** medical condition and any progress you believe you have made since you stopped working: _____

List ***all*** the medical problems for which you see a doctor: _____

List ***all*** medications you are ***currently*** taking along with their dosage and frequency: _____

Do you live alone? ☐No ☐Yes Are you married or have a significant other? ☐No ☐Yes
If you are married or have a significant other, does this person work? ☐No ☐Yes If yes, what is their occupation: _____
Do you have dependent children ☐No ☐Yes If you have dependent children, state their names and dates of birth: _____

What is your height? _____ What is your weight? _____ lbs/kgs

EDUCATION AND WORK EXPERIENCE

Please indicate the extent of your formal education (*circle one*)
Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School
If your education exceeds 12th grade, please indicate your major: _____

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

Job Title / Employer Name	Duties	Dates Worked
(1)		
(2)		
(3)		
(4)		

Did any of the positions listed above require additional training on your part? ☐No ☐Yes If yes, please indicate the nature and type of training (on the job, course work, etc.): _____

What do you perceive to be your current restrictions and limitations? _____

If retraining were made available to you, what occupation(s) would you be interested in? _____

PERSONAL CARE

Describe any changes in your sleeping habits since your condition began: _____

Do you need any assistance in dressing and/or grooming? ☐No ☐Yes If you need assistance, describe the help you require ***and*** how frequently:

Do you have problems with your memory? ☐No ☐Yes If you have problems with your memory, please describe the problems and how often they occur: _____

Do you prepare your own meals? ☐No ☐Yes If you prepare your own meals, which meals do you prepare?
☐ Breakfast ☐ Lunch ☐ Dinner If you do not prepare your own meals, who helps you? _____

Have your eating habits changed since your condition began? ☐No ☐Yes
Provide examples of the type(s) of changes in your eating habits: _____

HOUSEHOLD CARE

Are you responsible for the financial management of your household? ☐No ☐Yes If you are responsible for the financial management of your household, explain what you do (for example, write checks, pay mortgage, maintain bank records, make bank deposits, etc.): _____

If you are not responsible for the financial management of your household, who is? _____

Do you do housework? ☐No ☐Yes If you do housework, check the kinds of household activities you do:
☐Laundry ☐Dusting ☐Vacuuming ☐Washing dishes ☐Household repair ☐Car Care ☐Garden and lawn care ☐Trash ☐Recycling ☐Other *Specify:* _____

If you do not do household duties, please indicate who does the household duties for you: _____

How often do you do household activities? ☐Daily ☐Twice a week ☐Weekly ☐Monthly
Approximate time spent on household activities: Daily? _____ Weekly? _____ Monthly? _____
Describe any changes in your ability to care for your household and any assistance required since your disability began: _____

Do you drive? ☐No ☐Yes
Do you have a valid driver's license? ☐No ☐Yes
Do you take public transportation? ☐No ☐Yes Do you need assistance to travel? ☐No ☐Yes
If you need assistance to travel, describe why you need assistance, who assists you, and any changes in your travel since your condition began:

Do you shop? ☐No ☐Yes
What kinds of shopping do you do? ☐Food ☐Clothes ☐Gifts ☐Other *Specify*: _____

How often do you shop? ☐Daily ☐Twice a week ☐Weekly ☐Monthly
Approximate time spent on shopping? Daily? _____ Weekly? _____ Monthly? _____
Do you require assistance when you shop? ☐No ☐Yes If you require assistance when you shop, describe the assistance you require:

If you have childcare responsibilities, answer the following questions:
What care are you able to provide for your child/children/grandchildren:
☐Bathe ☐Change Clothes ☐Change Diaper ☐Feed ☐Carry ☐Play activities ☐Lift ☐Read
☐Other *Specify:* _____
Approximate time spent on childcare activities: Daily? _____ Weekly? _____ Monthly? _____

Do you require assistance to perform any of these childcare activities? ☐No ☐Yes If you require assistance to perform childcare activities, describe the assistance you need, who provides assistance, and how frequently do you require this assistance: _____

INTERESTS AND HOBBIES

Do you read? ☐No ☐Yes
If you read, what do you read? ☐Books ☐Magazines ☐Newspapers ☐Other *Specify:* _____
Approximate time spent on reading: Daily? _____ Weekly? _____ Monthly? _____

Do you watch TV? ☐No ☐Yes If you watch TV, how many hours do you watch daily? _____

Do you use a computer? ☐No ☐Yes If yes, how often and for what purpose? _____
In what types of hobbies or activities do you participate?
☐Fishing ☐Crafts ☐Sewing ☐Swimming ☐Bowling ☐Continuing Education Courses
☐Movies ☐Sports ☐Other *Specify:* _____

How often do you engage in these activities/hobbies? ☐Daily ☐Twice a week ☐Weekly ☐Monthly

Do you travel in excess of thirty miles from your home? ☐No ☐Yes If yes, how do you travel and how frequently do you travel: _____

_____

_____

SOCIAL CONTACTS

Are you an active member of any club(s) or organization(s)? ☐No ☐Yes If you are an active member, describe your responsibilities and activities:

_____

_____

How often do you participate in these activities? ☐Daily ☐Twice a week ☐Weekly ☐Monthly
Do you hold any positions in your club(s) or community organization(s)? ☐No ☐Yes If you hold any positions, describe them: _____

_____

_____

Do you do volunteer work? ☐No ☐Yes If you do volunteer work, describe your volunteer activities, including the location, duties performed, hours and frequency of participation: _____

_____

Do you visit with friends or relatives? ☐No ☐Yes If yes, how often do you visit? ☐Daily ☐Weekly ☐Weekends ☐Monthly
Estimate how long these visits last (i.e., number of hours): _____
Has there been any change in your social contacts since your disability began? ☐No ☐Yes If there has been any change in your social contacts or you require assistance to maintain these social contacts, describe the change(s) and assistance you require: _____

_____

OTHER INFORMATION

Have you participated in a rehabilitation or retraining program? ☐No ☐Yes If you have participated in a rehabilitation or retraining program, provide the name, address and telephone number of the program: _____

_____

Do you believe that you will be able to return to work? ☐No ☐Yes If you do not believe that you will be able to return to work, describe the reason(s) supporting your belief: _____

List all your current sources of income and the amount received from each source: _____

_____

What is the status of your Social Security disability claim? ☐None ☐Pending ☐Approved* ☐Denied ***If your claim for Social Security benefits has been approved and we have yet to be notified, please provide a copy of your award notice with this form.**

We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ Yes	☐ No	Social Security Disability or Retirement	☐ Yes	☐ No	Unemployment Benefits	☐ Yes	☐ No
Vacation/Bonus Pay	☐ Yes	☐ No	Retirement Benefits	☐ Yes	☐ No	Other Income Benefits	☐ Yes	☐ No
Automobile No-Fault	☐ Yes	☐ No	Short Term Disability	☐ Yes	☐ No	Workers' Compensation	☐ Yes	☐ No

If you have answered yes to any of the above options, please list any other income benefits that have been approved including the benefit amount and the benefit effective date (please use separate sheet if necessary): _____

Since ceasing work, have you performed work for any other employer or self employment? ☐ No ☐ Yes If Yes, please indicate the name and contact information for your employer: _____

_____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature_____Date_____

Fraud Warnings

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA WARNING: 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.

COLORADO WARNING: WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA WARNING: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA WARNING: WARNING: 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.

GEORGIA WARNING: WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

KANSAS WARNING: 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 may be guilty of fraud, as determined by a court of law, and subject to fines, confinement in prison and/or denial of insurance benefits.

KENTUCKY WARNING: WARNING: 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.

LOUISIANA WARNING: 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 may be guilty of a crime and subject to fines, and confinement in prison.

MAINE WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NEW HAMPSHIRE WARNING: WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: WARNING: 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.

TENNESSEE WARNING: WARNING: It is a crime to knowingly supply 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.

WASHINGTON WARNING: WARNING: 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.

Signature: _____ Date: _____

Underwritten by: Madison National Life Insurance Company, Inc.
Administered by: North American Benefits Company

Mail to:
North American Benefits Company
P.O. Box 3056
Southeastern, PA 19398-3056
1.800.346.7813

ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote a return to work. This form must be completed by a physician.

Name of patient:_____ Date of birth:_____

Address:_____
Street City State Zip

A. DIAGNOSIS / HISTORY

Primary diagnosis:_____ ICD-9 code:_____
Secondary diagnosis:_____ ICD-9 code:_____
Other diagnoses and ICD codes related to this claim:_____

DSM IV Axis I – V (GAF):_____
Symptoms:_____

Is the condition primarily related to: ☐ Employment ☐ Illness ☐ Mental Disorder ☐ Alcohol or Drug Dependence ☐ MVA ☐ Pregnancy ☐ Injury

Date patient became unable to work due to this impairment? Month_____ Day_____ Year_____

Date your patient can return to work: Part time:_____ Full time:_____
OR unable to determine, due to:_____ Follow up in: _____

Patient's Height: _____ Patient's Weight: _____ BP:_____ Patient's Dominant Hand: ☐ Right ☐ Left
Date symptoms first appeared:_____ Date of first visit to you for this condition:_____
Date of most recent visit:_____ Date of next visit:_____
Has your patient ever had the same or similar condition? ☐ No ☐ Yes If yes, indicate when and describe:_____

B. TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.):_____

Treatment complicated by: ☐ Employer / Employee conflict ☐ Significant emotional or behavioral disorder
☐ Alcohol or Drug Dependence ☐ MVA ☐ Other _____

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper):_____

Frequency with which you see your patient: ☐ Weekly ☐ Monthly ☐ PRN ☐ Other:_____
Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? ☐ No ☐ Yes If yes please indicate to whom and dates:

If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? For example, have you had contact with the patient's employer regarding possible job modifications or gradual return to work? ☐ No ☐ Yes If yes please describe the return to work plan:_____

C. HOSPITALIZATION: (If not hospitalized please proceed to next section.)

If patient was hospitalized, please provide dates: Admitted_____ Discharged_____
Admitting diagnosis:_____ ICD-9 code:_____
Discharge diagnosis:_____ ICD-9 code:_____
Name of hospital:_____ Name of doctor seen at hospital:_____
Address:_____
Street City State Zip Code

D. SURGERY: (If surgery was not performed or is not anticipated to be necessary in the future please proceed to next section.)

Was surgery performed? ☐ No ☐ Yes If yes indicate procedure and date of surgery: _____

Is surgery planned? ☐ No ☐ Yes If yes indicate planned procedure and anticipated date:_____

Name of Patient:_____ Date of Birth_____

E. PREGNANCY: (If patient is not pregnant please proceed to next section.)

If disability is related to pregnancy, please provide the following: LMP_____ First obstetric visit:_____
Expected date of delivery_____ Actual date of delivery_____ Type: ☐C-Section ☐ Vaginal
Have there been complications resulting in disability prior to delivery? ☐ No ☐ Yes If yes indicate the type of complication:_____

F. ASSESSMENT

Describe your patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
Has your patient reached maximum medical improvement? ☐ No ☐ Yes
If your patient has not reached maximum medical improvement, when do you expect a fundamental or marked change in his/her condition?
☐ Never ☐ Condition expected to regress ☐ Condition expected to improve, State anticipated date_____ ☐Unable to determine
Is confinement to bed or home medically required? ☐ No ☐ Yes. If yes, please indicate duration of confinement. _____

G. RESTRICTIONS AND LIMITATIONS

If physical or psychiatric limitations exist, how long do you feel that these limitations will last?_____
Has your patient provided a self-report of his/her job tasks? ☐ No ☐ Yes
Based on your knowledge of your patient's job, what reasonable work or job site modifications could the employer make to assist him/her to return to work?

Level of functional impairment:

In a work day, given two breaks and a meal break, your patient can:
Lift (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Carry (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently (how frequently)_____

If allowed positional changes, patient can: (please circle one for each)
Sit: 8 7 6 5 4 3 2 1 0 (hrs)
Stand: 8 7 6 5 4 3 2 1 0 (hrs)
Walk: 8 7 6 5 4 3 2 1 0 (hrs)
Alternately sit/stand : 8 7 6 5 4 3 2 1 0 (hrs)

If the total number of days that the patient can work during a week is limited, please specify the number of days the claimant can work per week. _____

Patient can work with arms in the following positions:
Right arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes
Left arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes

Patient can use arms/hands for repetitive action such as:
Right arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes
Left arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Patient can use his/her head and neck in:
Flexion ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Extension ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Rotation ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Mental Impairment (if applicable)

Please define "stress" as it applies to this claimant: _____
What stress and problems in interpersonal relations has this claimant had on the job? _____

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations. (No limitations.)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight limitations.)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. (Moderate limitations.)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked limitations.)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment. (Severe limitations.)

Remarks: _____
What obstacles prevent a return to work?_____
If no, would you like assistance in developing a return to work plan? ☐ No ☐ Yes
Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in finding a new job, or in designing a retaining plan which would allow a return to work)? ☐ No ☐ Yes
Comments:_____

PLEASE READ CAREFULLY*************************************

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

I have received and read the fraud warning statements provided with this form.

Physician's signature:_____ **Date:**_____

Physicians name (please print):_____ Specialty:_____

Address:_____ City_____ State:_____ Zip code:_____

Phone number:_____ **Medical record department fax number:**_____