

VB Continuing Waiver of Premium Claim Form Employee Statement



The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We or "ManhattanLife."

Life, Specified Disease/Critical Illness, Hospital Indemnity, and Accident Insurance products insured by ManhattanLife.

Employee Information:

Subscriber Name _____ Policy No. _____
(If this is a name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.)

Date of Birth _____ Mailing Address _____

City _____ State _____ ZIP Code _____

Phone No. _____

Do you have Disability coverage with ManhattanLife? Yes No If yes, Plan ID No. _____

If no, are you currently receiving disability payments through another carrier or SSDI? Yes No

Disability carrier name _____

Address: _____

Phone No. _____ Plan ID No. _____

Claim Information:

What was your occupation at the time of your disability? _____

Describe the current nature of your illness or describe how and where your accident occurred.

What aspect of your condition makes you unable to perform your occupation or any occupation?

Have you returned to work? Yes No If yes, date returned: _____ Full-Time Part Time

Employer _____ Occupation _____

Street Address _____

City _____ State _____ ZIP Code _____

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 6)

The above Statements are true to the best of my knowledge and belief.

Signature of Policyholder

Printed Name

Date

VB Continuing Waiver of Premium Claim Form Physician Statement



Patient Information:

Patient's Name _____ Date of Birth _____ Height _____ Weight _____
Date you advised the patient they should cease work: _____

Treatment Information:

Current Diagnosis (including any complications) & symptoms _____
Diagnosis Code(s) _____
Date of patient's last visit _____ **(Please submit records from this visit)**

Frequency of visits: Weekly Monthly Other (specify) _____
Objective findings (including current x-rays, EKG, laboratory data and any clinical findings) _____

Patient's progress: Recovered Improved Unchanged Regressed
Patient is currently: Ambulatory House Confined
 Bed Confined Hospital Confined

Patient's current treatment plan for this condition (including any rehab programs) _____

List any current Medications (include date of change if applicable) _____

Have any subsequent surgeries been performed? Yes No If "Yes", surgery date _____

CPT Code(s)/ procedure performed _____

Has patient been hospital confined? Yes No

If "Yes", Admit Date _____ Discharge Date _____

Hospital Name: _____ Address _____

Reason for hospitalization (if different from reason for disability): _____

Impairment:

Cardiac Functional Capacity Limitations (American Heart Association – if applicable):

Class 1 (None) Class 2 (Slight) Class 3 (Marked) Class 4 (Complete)

Blood Pressure (Last Visit) _____

Physical Impairments (As defined in Federal Dictionary of Occupational Titles):

- Class 1 - No Limitation of functional capacity capable of heavy work. No restriction. (0%-10%)
- Class 2 - Medium manual activity. (15% - 30%)
- Class 3 - Slight limitation of functional capacity; capable of light work. (35% - 55%)
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. (60%-70%)
- Class 5 - Severe limitation of functional capacity; capable of minimum sedentary activity. (75% - 100%)

Comments : _____

VB Continuing Waiver of Premium Claim Form Physician Statement



Impairment continued:

Mental Impairments

- 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 interpersonal relations. (Slight limitations)
- Class 3 – Patient is able to engage in only limited stress situations and engage in 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)

Comments: _____

Functional Ability:

Estimate your patient's ability to perform the following tasks based on your knowledge of the patient.

Activity:	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Number of Hours (less than 3,4/6 or 6/8 hours)
Standing	<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"/>	_____
Sitting	<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"/>	_____
Twisting/bending/stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Operating heavy machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keyboard Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repetitive hand motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Lifting/Carrying				Pushing/Pulling			
	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)
Up to 10lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the disability is related to a psychological disorder, has the Global Assessment of Functioning (GAF) been performed? Yes No

If yes, complete the DSM-IV-TR axis diagnosis section below:

Axis I _____ Axis II _____ Axis III _____ Axis IV _____ Axis V _____ GAF or the DSM-V; WHODAS 2.0 Score _____

Date Assessed _____

VB Continuing Waiver of Premium Claim Form Physician Statement



Prognosis and Restrictions:

Is patient currently disabled from their job? Yes No from **any** other work? Yes No

When do you expect a fundamental or marked change in the patient's condition?

Less than 1 month 1 month 2-3 months 4-6 months Other _____

What date can employment resume? _____

What date can employment resume in another occupation? _____

If the return to work date is unknown at this time, please indicate date of next appointment: _____

Describe fully how the patient's conditions/limitations are affecting their ability to work, including any physical restrictions:

Additional Comments: _____

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 6)

The above Statements are true to the best of my knowledge and belief.

Printed Name of Physician _____ Phone No. _____

Specialty _____ Tax ID _____

Street Address _____ City _____ State _____

ZIP Code _____ Fax No. _____

*Signature of Attending Physician**

Date

*Form must be signed by a Medical Doctor duly licensed in the state were the services are rendered

Claim Form Addendum: Fraud Warning and State Versions

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Alaska** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **Arkansas** 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. **Arizona** 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** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Colorado** 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 damages. 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. **Delaware** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **District of Columbia** 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** 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. **Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **Kentucky** 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** 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. **Maine** 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** 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. **Minnesota** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **New Hampshire** 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** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New Mexico** 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 civil fines and criminal penalties. **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. **Ohio** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Oklahoma** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **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 such person to criminal and civil penalties. **Puerto Rico** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. **Rhode Island** 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. **Tennessee** 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. **Texas** 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. **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. **Washington** 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. **West Virginia** 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.