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	riber NamePolicy No name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.) of BirthMailing Address			
(If this is a name change, provide a copy of an updated driver's license, government is Date of BirthMailing	Address	se or divorce decree.)		
City				
Phone No				
Do you have Disability coverage with ManhattanL			ID No.	
If no, are you currently receiving disability paymen	nts through an	other carrier or S	SDI? 🗌 Yes 📃 N	o
Disability carrier name				
Address:				
Phone No			an ID No	
Claim Information:				
What was your occupation at the time of your disal	bility?			
Describe the current nature of your illness or describe	ribe how and v	where your accider	nt occurred.	
What aspect of your condition makes you unable to	o perform your	r occupation or an	y occupation?	
Have you returned to work? Yes No If yes, d	late returned:_		Full-Time	Part Time
Employer		Occupation		
StreetAddress				
City	State	ZI	P 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

Authorization to Release Information For the Use and Disclosure of Protected Health Information



Patient's Date of Birth _____

Patient's Name

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

- 1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
- 2. I authorize all health care professionals to disclose my protected health information to ManhattanLife,
- 3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
- 4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
- 5. I authorize only designated staff of ManhattanLife to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
- 6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
- 7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Attn: Claims Department PO Box 926169 Houston, TX 77292. This revocation shall become effective on the date it is received by ManhattanLife. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim. A photocopy or facsimile of this authorization shall be valid as the original.

Signature	Printed Name	Date		
I have legal authority* under the laws of the Sta	te of	to make health care decisions on behalf of		
, the individual to wh	om the use and/or dis	closure of protected health information above		
applies and execute this Authorization in my capacity as Authorized Representative thereof.				

Name of Authorized Representative/Parent	Relationship to Applicant	Date	
or Guardian			

*A copy of the legal authority document must be on file with ManhattanLife.

<u>VB Continuing Waiver of Premium Claim Form</u> <u>Physician Statement</u>



Patient Information:					
Patient's Name	Dat	te of Birth		Height	Weight
Date you advised the patient they sho	ould cease work:		-		
Treatment Information:					
Current Diagnosis (including any co	-				
Diagnosis Code(s)					
Date of patient's last visit		(Please su	ubmit record	s from this vis	sit)
Frequency of visits: Weekly	Monthly Oth	er (specify)			
Objective findings (including curren	ıt x-rays, EKG, la	aboratory data and	d any clinical fir	ndings)	
Patient's progress: Recovered	Improved	Patient is cur	rently: Am	bulatory 🗌 H	ouse Confined
Unchanged	l Regressed		Bed	l Confined 🗌 H	ospital Confined
Patient's current treatment plan for	0	including any reha			
List any current Medications (inclue	de date of chang	e if applicable)			
Have any subsequent surgeries been	n performed?	Yes No If "	Yes", surgery da	ate	
CPT Code(s)/ procedure performed					
Has patient been hospital confined?	Yes No)			
If "Yes", Admit Date					
Hospital Name:		-			
Reason for hospitalization (if differe					
Impairment:					
Cardiac Functional Capacity Lim	itations (Americ	an Heart Association	ı – ifannlicahle).		
Class 1 (None) Class 2 (Slig)					
Blood Pressure (Last Visit)			s 4 (Complete)		
blood Flessure (Last Visit)					
Physical Impairments (As defined in	n Federal Diction	nary of Occupation	nal Titles):		
Class 1 - No Limitation of fu			work. No restri	ction. (0%10%)	
Class 2 - Medium manual act					
Class 3 - Slight limitation of t Class 4 - Moderate limitation					my activity
(60%- 70%)	i or runctional ca	ipacity, capable of	ciericai/aummi		iry activity.
Class 5 - Severe limitation of	functional capa	city; capable of mi	nimum sedenta	ry activity. (75%	-100%)
Comments :					

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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 Walking Sitting Kneeling Twisting/bending/stooping Reaching above shoulder level Operating heavy machinery Keyboard Use Repetitive hand motion					
Lifting/O					g/Pulling
Never Occasionally (0%) (1-33%)	Frequently (34-66%)	y Continuously (67-100%)	V Neve (0%)		Frequently Continuously (34-66%) (67-100%)
Up to 10lbs.					
11 to 20lbs.					
21 to 50lbs.					
51 to 100 lbs.					
If the disability is related to a psy performed? Yes No	chological d	lisorder, has the	e Global Assess	ment of Functioni	ng (GAF) been
If yes, complete the DSM-IV-TR a	axis diagnos	is section below	v:		
Axis I Axis II Axis III	_Axis IV	_Axis VGAF	or the DSM-V;V	WHODAS 2.0 Score	
Date Assessed	_				

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Prognosis and Restrictions:		~
Is patient currently disabled from thei When do you expect a fundamental or	-	ny other work? 🗌 Yes 📄 No ndition?
Less than 1 month 1 month	2-3 months 4-6 months	Other
What date can employment resum	ne?	
What date can employment resum If the return to work date is unknown a	e in another occupation? at this time, please indicate date of	next appointment:
Describe fully how the patient's condit	ions/limitations are affecting their	ability to work, including any physical restrictions:
Additional Comments:		
-	a false or deceptive statement may	ilitating a fraud against an insurer, submits an be subject to prosecution and punishment for 5)
The above Statements are true to		
Printed Name of Physician		Phone No
Specialty	Tax ID	
Street Address	City	State
ZIP CodeF	ax No	
		<i></i>

*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.