VB 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.

Subscriber's 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. _____

Has the Subscriber retired? ☐ No ☐ Yes If yes, date of retirement _____

Primary Care Physician's Name: _____
Address_____
Phone No._____

Do you have Disability coverage with ManhattanLife? ☐ Yes ☐ No If yes, Policy No._____

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

If yes, Disability Carrier Name_____ Policy No. _____
Address_____
Phone No._____

Employer's Name (at the time your disability started)_____
Street Address_____ City_____ State_____
ZIP Code_____ Phone No. _____
Occupation (at the time your disability started)_____
List the job duties/responsibilities of your occupation at the time of the disability_____
_____
_____
_____

Date of the first symptoms of the illness or date of accident_____
Date you were first treated_____
First date you were unable to work because of your disability_____
Describe the onset and nature of your illness or describe how and where the accident occurred _____
_____

What aspect of your condition made you unable to perform your job?_____
_____
_____

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

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Are you employed with any other company other than the employer listed above? ☐ Yes ☐ No

Employer_____ Occupation_____

Datesworked_____

Physician information:

Attending (Treating) physicians:

Physician's Name	Address	Phone Number

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 10)
The below Statements are true to the best of my knowledge and belief

_____ _____ _____

Signature of Policyholder | Printed Name | Date

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If the claim is being filed for a disability within the first year of the policy, complete both the physician and medication information below:

Physician information:

List all physicians that treated the patient in the five years prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

Medication information:

List all medication being taken by you:

Medication	Prescribing Physician	Date Prescribed

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

Patient's Name_____**Policy No.** _____

Patient's Date of Birth _____

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 State of_____to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies and execute this Authorization in my capacity as Authorized Representative thereof.

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

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

VB Waiver of Premium Claim Form
Employer Statement

Employer Information:

Employer's Name_____ StreetAddress_____

City_____ State_____ ZIP Code_____

Employer Contact Name_____ Phone No._____

For Group Sponsored Plans, what is the group number_____

Employee Information:

Employee's Name_____ Policy No._____

Date of Birth_____ Street Address_____

City_____ State_____ ZIP Code_____

Employee's Date of Hire_____ Date Employee Last Worked_____

What class is the Employee in (if applicable)_____

Reason for stopping work:

☐ Sickness ☐ Accident ☐ Granted LOA ☐ Laid Off ☐ Dismissed
☐ Resigned ☐ Retired ☐ Other

Has employee returned to work? ☐ Yes No Full-Time_____
Part-Time_____

If No, what is the anticipated return to work date_____

Are they still an employee? ☐ Yes ☐ No If No, when did employment terminate_____

Reason for termination of employment_____

Occupation at Time Last Worked_____

(Please attach a copy of the job description to this form)

Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job using the definitions below for the frequency:
Indicate the average weight when applicable.

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Frequency of Occurrence				
	N/A	**Occasionally**	**Frequently**	**Continuously**	
Activity:					
Standing	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Bending, twisting or stooping	☐	☐	☐	☐	
Operating heavy machinery	☐	☐	☐	☐	
Reaching/working overhead	☐	☐	☐	☐	
Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐	
Pushing or pulling	☐	☐	☐	☐	_____lbs.
Lifting or Carrying	☐	☐	☐	☐	_____lbs.

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What are the major tasks of the employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks?

_____ %

_____ %

_____ %

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

Employer's Name_____ Phone No._____

Address_____ Fax No._____

_____

Printed Name of Person Completing Form

_____ _____

Signature of Authorized Representative Date

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ManhattanLife

Disability Information:

Patient's Name_____ Date of Birth_____ Height _____ Weight _____

Is the disability related to: Illness Accident Mental/Nervous Condition

Date you advised the patient they should cease work:_____

If pregnancy, estimated date of delivery_____

For conditions other than pregnancy, the date symptoms first appear, or accident occurred :_____

Is the condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown

Treatment Information:

Diagnosis (including any complications) ICD-10 Code(s) _____

Date of patient's first visit for this condition

Date of last patient 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 ☐ **Patient is currently:** Ambulatory ☐ House Confined ☐

Unchanged ☐ Regressed ☐ Bed Confined ☐ Hospital Confined ☐

Current treatment plan for this condition (including any rehab programs/medications)_____

_____

Is the patient on any medications? ☐ Yes ☐ No If "Yes", list medications.

Medications:_____

Have any surgeries already been performed? ☐ Yes ☐ No If "Yes", surgery date_____

CPT Code(s)/ procedure performed _____

If "No", are any surgeries scheduled? ☐ 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_____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes", indicate type of condition, treatment date(s), and treatment provided:_____

_____

Please provide the name and address of other treating physician(s)

Physician's Name	Address	Phone Number

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Physician Statement

ManhattanLife

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 Four Visits)_____ _____ _____ _____

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. (75%-100%)
- ☐ Class 5 - Severe limitation of functional capacity; capable of minimum sedentary activity. (75% - 100%)

Comments_____

_____

_____

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%)
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Twisting/bending/stooping	☐	☐	☐	☐
Reaching above shoulder level	☐	☐	☐	☐
Operating heavy machinery	☐	☐	☐	☐
Keyboard use	☐	☐	☐	☐
Repetitive hand motion	☐	☐	☐	☐

Number of hours
(less than 3, 4/6 or 6/8 hours

_____

_____

_____

	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 10 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

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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_____

Prognosis and Restrictions:

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

If the patient works from their home, would this change their disability status or the length of disability? ☐ Yes ☐ No

If "Yes", explain:_____

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 in the patient's regular occupation?_____ ☐ Full-time ☐ Part-time

What date can employment resume in another occupation? _____ ☐ Full-time ☐ Part-time

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:_____

_____

_____

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

Printed Name of Physician_____ Phone No._____

Street Address_____ Specialty_____

City_____ State_____ ZIP Code_____ Tax ID_____

Email Address_____ Fax No._____

_____ _____

Signature of Attending Physician* Date

*Note form must be signed by medical doctor duly licensed in the state where 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.