

# GROUP LONG TERM DISABILITY CLAIM APPLICATION

## Send completed application to:

Claims Department PO Box 1230 Enfield, CT 06083 Toll Free Number: 1-877-377-6773 Fax Number: 1-877-737-3650

To avoid unnecessary delays, please follow these instructions when applying for disability benefits.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

All four sections of this claim application must be completed:

- Section 1: *Authorization and Disclosures* (to be completed by the employee)
- Section 2: *Employee's Statement* (If you have already returned to work full-time or if you are filing a maternity claim, only complete questions #1 through #15. For all other claims, answer all questions in this section)
- Section 3: Employer's Statement
- Section 4: Physician's Statement

When ALL sections of this form have been completed, please fax or mail it to us. Use the fax number or address above that corresponds to the type of disability for which you are applying.

It is your responsibility and the responsibility of your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

#### Section 1: To Be Completed By Employee

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

#### то:

- Physicians and other Medical Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
- Group Policyholders, Contract Holders/Vendors, Health Benefit Plan Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers and Pre-Paid Health Plans
- Pharmacies
- State Vocational Rehabilitation agencies and other providers of Rehabilitation Services
- Attorney Representatives
- Pharmacy Benefit Manager

You are authorized to provide any information related to my medical condition and to job modifications/accommodations with my current or future employer to:

- Symetra Life Insurance Company in partnership with Custom Disability Solutions ("CDS"),
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, and service consultants and other personnel involved in the administration, evaluation, analysis and management of the plan and/or claim.

This includes, but is not limited to, any:

- Records, test results, data, and information about medical care, history, diagnosis, prognosis, treatment, and supplies;
- Employment-related information;
- Income-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, analyzing, managing and / or administering my claim for long term disability benefits, salary continuation, workers' compensation and/or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), for assessing and developing a vocational rehabilitation plan, and for other business purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program plan under which I may be a participant, claims investigators, attorneys, service consultants and any other entities, including the claimant's treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization will no longer be protected under HIPAA.

I understand that this authorization shall remain in force for the duration of my claim for benefits under the Benefits Program or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed. I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of my initial authorization, may impair the ability of Symetra Life Insurance Company, in partnership with any claim administrator to process my claim and may be a basis for denying or terminating my claim for benefits.

Claimant's Signature:	Date:	Date of Birth:				
Claimant's Full Name:	Employer:	Odyssey Systems Consulting Group, Ltd.				
If the insured is unable to sign, an authorized representative may sign below for the insured.						
Representative Signature:	Date:					
Description of Representative's Authority to Sign:						

### **Section 1: Continued**

#### Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

<u>AL:</u> 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.

<u>AR, LA, RI, WV</u>: 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.

<u>AZ</u>: 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.

<u>CA</u>: 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.

<u>CO</u>: 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.

<u>DE:</u> Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

<u>DC</u>: 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.

<u>FL</u>: 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.

<u>ME</u>: 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.

<u>MD</u>: 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.

<u>NH</u>: 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.

<u>NJ</u>: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

<u>NM</u>: 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.

<u>NY</u>: 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.

<u>OK</u>: 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.

<u>PA</u>: 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.

TN, VA, WA: 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.

TX: 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.

# Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

Writ	e "NA" in non-applicable section	ons.					
1	Employee Name		2 Social Security No.				
	Street/Box/Apt.			<b>3</b> Phone No. ( )			
	City, State, Zip			4 Date of Birth			
5	Height	6 Weight	7 🗆 Male 🗆 Female	8 Employer Name Odyssey Sy	vstems Consulting Group. Ltd.		
9	Occupation	<b>10</b> List Occupation Duties			stenis constituing croup, Lita		
11	Date of accident or date of first symptoms		12 Last Day Worked	<b>13</b> Are you unable to work due □ Injury □ Illness	e to: (check one)		
14	Date you Returned to Work				□ Full Time □ Part Time		
15	If you have not returned to v	vork, when do you expect to	return?	Full Time     Part Time			
16	Describe in detail, when, wh	ere and how accident occur	red, or nature of disability	and first symptoms			
17	Is your accident or illness re If yes, explain:	lated to your occupation?	□Yes □No				
18	Have you filed a Workers' C If no, explain:	ompensation Claim?	□ Yes □ No	If no, do you intend to?   Yes	□ No		
19	When were you first treated	for your illness or accident?					
	Hospital		Address		Date(s)		
	Doctor		Address		Date(s)		
20	Have vou ever had same or	similar condition in the past	?	If yes, list name and address of	Hospital/Doctor below		
	Hospital		Address	, , , , , , , , , , , , , , , , , , , ,	Date(s)		
	Doctor		Address		Date(s)		
21	, ,	following? (Check each ben mount Begin date I	lefit you are receiving) End date	Amou	nt Begin date End date		
				· · · •			
	Social Security \$		Other (	Indiv. or Group)* \$			
	State Disability \$		Auto In	<b>o</b> ,			
	Canadian Pension Plan \$ *If yes, give name and address of Insurer below						
insu	rer Name(s)		Address				
	□ Single □ Married □ Divorced □ Widowed	23 If married, spouse's na	ame and Social Security N	lo.	24 Spouse Date of Birth		
25	Is Spouse Employed?	26 List children under age	e 25 (Names and Dates of	Birth)			
27	<ul> <li>If benefits are approved, do you want the minimum \$88.00 per month withheld from your check for Federal Income Tax purposes? </li> <li>Yes No If you want more withheld, please state dollar amount you want withheld \$</li> <li>By signing below, I attest that I have read and understood the fraud warning applicable to me. I also attest that the statements above are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)</li> </ul>						

Date

### Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections

vvnie	while NA in non-applicable sections.										
1	Employee's Name						2 Social Security No.				
	Street/Box/Apt.							3 Date of Birth			
	City, State, Zip						4 Regularly S	cheduled	Hours Per Week		
5	Date of Hire			<b>6</b> Em	nployee's l	LTD E	ffective Date	•	7 Occu	pation	
<b>8</b> 01-0	Policy No. 21140-00		<b>9</b> Po	licy Divi	sion No.				10 Poli	icy Class	
11	Employee's Work Schedule	e □ Full	Time	🗆 Pa	art Time	[	□ Exempt	🗆 Non-E	xempt	□ Seasonal	
12	Check Regular Workdays	□ Sur		on	□ Tues	[	□Wed	□ Thurs	🗆 Fri	□ Sat	
13	□ Terminated □ Leave of Absence □ Other: Free □ Laid Off □ Sick Leave						How was employee paid? (check frequency and types) equency:  Weekly  Biweekly  Semi-Monthly  Monthly pe(s): Hourly  Bonus Salary  Commission				
15	Salary Prior to Date Last W	orked	16	Date La	ast Salary	Increa	se				
	Base Weekly Wages \$		17	Employ	ee Work S	Schedu	ule at Time L	ast Worked			
					Day	/s per	week				
	Bonus \$				Ηοι	urs pe	r week				
18		9 Hours W		Day	20 First D	Day Ou	ut <b>21</b> Has	Employee Retu	rned to wo	ork? 🗆 Yes 🗆 No	P□ Full Time
									□ Part Time		
22	Date Paid Through		For	□ Sala	ry Continu	ation					
23	Does employee contribute t	toward the	LTD premiu	ım? 🗆	Yes 🗆 N	0	lf ye	es, 🗆 Pre-Tax	Post-T	ax	
_	If Post Tax,% pa	id by emple	oyer	% pa	aid by emp	oloyee					
24	Employee is Eligible for:	Yes No	If yes, We Monthly A		Wk Mo	Prov	vider Name/A	Address		Date Benefits Begin	Through
_	Salary Continuation		\$								
	Disability Pension		\$								
	Retirement Pension		\$								
	State Disability		\$								
	Unemployment		\$								
	Social Security		\$								
	Workers' Compensation		\$								
	Has Workers' Comp. claim been filed?		If Workers' Compensation has been denied, submit copy of denial with this claim.								
25											
	What is the name of the per	rson we sh	ould contac	t if we ic	dentify a re	eturn t	o work optior	n?			
26	Employee's medical insurance carrier or HMO (provide policy or ID No.) Name Address										

A Job Description is required if employee is out of work more than 6 weeks.

#### Section 3: Continued

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

27 Notice to Employers – Tax Services.

We will provide the tax services agreed upon at the time the policy was sold. Please contact the Claims Department if you have any questions regarding the specific Tax Services provided by Symetra.

**Symetra LTD Tax Services:** Our standard services include issuing checks to the claimants in arrears, withholding employee taxes if the benefit is taxable, paying the employer matching FICA, and preparing W-2s.

FICA taxes are applicable only for the first six calendar months from the last day worked and only if the benefit is taxable. The benefit is taxable if the employer paid all the premium or if the claimant paid the premium with pre-tax or grossed up dollars (considered employer paid). If the claimant paid all the premiums with post-tax dollars, then the benefit is nontaxable. If the premium payments are shared, then the benefit is taxable for the percentage that the employer paid the premium. FICA withholding is mandatory on all portions of the benefit paid with a pre-tax premium.

28	Employer's Name Od	Phone No. (	)	
	Street Address	City	State	Zip
201	Edgewater Drive, Suite 245	Wakefield	MA	01880
	Signature (The above statements a	are true and complete to the best of my knowledge)	Date	
	X			

	ction 4: To Be Co	mpleted By Physic	cian				
Patient Name			Date of Birth		Social Security No.		
Heig	Height Weight			Blood Pressure (last visit)			
1	Patient is/was unable to w	vork due to: (check one)	🗆 Injury 🛛 Illness	Pregnancy			
2	Diagnosis (include compli	cations and ICD 9 or ICD 1	0 codes)				
For	Normal Pregnancy, comp	lete items 3-6 then skin	to item 25				
3	What was LMP date?	4 What is the expected		5 Date First Treated		6 Date Last Treated	
For	all conditions except Nor	mal Pregnancy, complete	the following item	e			
7	When did symptoms first		8 Date you advised			ition due to injury or illness arising	
10	or accident happen? Has patient ever had sar	lf yes, state	to stop working when and describe		out of p	atient's employment?  Ves  No	
	similar condition?						
11	Date of First Visit		12 Date Last Visit		13 Freque	ency of Visits	
14		ys, EKG's, lab data and clir e page and to also include tes		15 Subjective Sympto	ms		
16	Nature of Treatment (sur	gery, medications, etc.) Pro	ovide medication dos	age and frequency			
47	Names and addresses of	f other physicians					
17	Names and addresses of						
18	Has patient been hospita	lized? □Yes □No	If Yes, give nam	e and address			
	From to			-			
19	Restrictions (what the pa	tient SHOULD NOT do)		20 Limitations (what th	e patient CA	NNOT do)	
21	Mental Impairment (if app	plicable) Provide 5 AXIS Di	agnosis				
	I		-	IV			
	II			V			
	111						
22	If this is a cardiac condition (American Heart Associa	apacity?	□ Class 1 - No Limitation □ Class 3 - Marked Limitation □ Class 2 - Slight Limitation □ Class 4 - Complete Limitation				
23	Patient released to return	n to work with restrictions		Date		•	
	Estimated return to work Restrictions effective thro	bugh		Date Date			
		kimum medical improvemer s permanent? $\Box$ Yes $\Box$		Date Date			
	Can patient work full time	e? □Yes □No Part Ti	imehrs/day	Date			
24	If employer can accommodate patient's limitations and restrictions, is patient able to return to work? □ Yes □ No If yes, what date could employment begin?						
25	Physician Name (Please	Print)			Degree		
	Specialty			Phone No.	I	Fax No.	
	Address		City		State	Zip	
	Signature (No Stamp) X	<u> </u>	<u>    I                                </u>	Tax ID No.	<u> </u>	Date	
				1			