

Disability Claim Form Employee Statement: Forza



ManhattanLife™

Employee'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 _____

Daytime Phone No. _____

Is this a new address? Yes No

Primary Care Physician's Name _____

Address _____

Phone Number _____

Employer's Name _____ Occupation _____

Physical Work Location (City and State): _____ Years at Location: _____

List the job duties/responsibilities of your occupation at the time of the disability **(and submit a job description):**

Is the disability related to:

Pregnancy Yes No **(If Yes** and prior to delivery, please submit medical records and flow charts)

Accident Yes No **(If Yes** and the accident was related to a Motor Vehicle Accident, please submit police report)

Illness/Non-Routine Care Yes No

Date of the first symptoms of the illness or date of accident _____

Date you were first treated _____

First date you were unable to work as a result of your disability

Did your injury or illness occur at work or as a result of your job? Yes No

If yes, did you inform your employer? Yes No

Reported To:

Employer Representative Name _____

Address _____ Phone No. _____

If work related, please explain _____

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? Yes No

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: _____

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

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

(If yes, please submit Disability Employer Statements from **ALL** employers)

Employer _____ Occupation _____

Dates Worked _____ Phone No. _____

Employment Income (Salary)
*Attach most recent paystub showing
year to date pay totals

Physician information:

Attending (Treating) physicians:

Physician's Name	Address	Phone / Fax Number

Have you ever been treated for the same or a similar condition in the past? Yes No

If yes, provide the prior Physician's Information:

Physician's Name	Address	Phone / Fax Number

Other Income Information:

Please indicate any additional income you are currently receiving:

Yes	No	Type	Amount	Frequency	Date Began	Date Ceased
		Social Security (Disability or Retirement)	\$ _____	_____	_____	_____
		State Disability	\$ _____	_____	_____	_____
		Retirement (normal, early or disability)	\$ _____	_____	_____	_____
		Worker's Comp/Occupational Disease *Attach WC Documentation	\$ _____	_____	_____	_____
		Group Disability	\$ _____	_____	_____	_____
		Employment Income (Salary) *Attach most recent paystub showing year to date pay totals	\$ _____	_____	_____	_____

If you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above?

Yes No

Benefit Type _____ Date Applied _____

Benefit Type _____ Date Applied _____

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Deduction of Premium

To keep your policy active premiums can be deducted from your disability benefit payments. By deducting premiums this will ensure that your policy stays current and eliminates the risk of your policy terminating for non- payment of premiums.

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 11)

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

Signature of Policyholder

Date

STOP

- **Sign and date the authorization on page 7 and include when returning the claim form**
- **If the disability date is within the first year of the policy, complete the information on page 4 and return with the claim form.**

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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

Direct Deposit Authorization



Check Action Account Type Ownership of Account

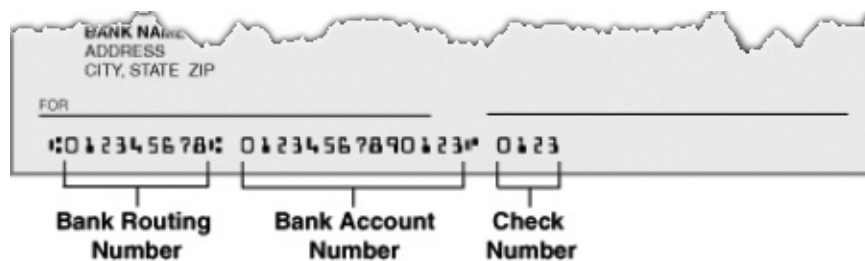
New Change Cancel Checking Savings Self Other

Policy Holder's Name _____ Policy Number _____

Bank Name _____

Bank Routing Number _____ Bank Account Number _____

Account Holder's Name _____



Terms and Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program, please read the following terms and conditions for participation carefully before making your decision. Not all policies may qualify.

1. Once the Form is received by ManhattanLife, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be canceled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife or cannot be made to your account, ManhattanLife will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be canceled by your financial institution or ManhattanLife. **Your participation will be canceled automatically if you terminate participation in the above Account(s).**

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature _____

Printed Name _____

Date _____

Mail to: ManhattanLife VB Claims
PO Box 926169
Houston TX 77292

Customer Care: 1-855-448-6982
Fax: 1-502-405-7107
Email: vbclaimssubmissions@manhattanlife.com

VB Disability Claim Form **Employer Statement: Forza**



All questions must be completed by your Manager or an authorized Personnel Department staff member.

Employee Information:

Employee's Name _____ Date of Birth _____

Policy No. _____

Job Title _____

Current Annual Base Salary* _____ *Not including overtime pay, bonuses, commissions, or extra compensation

Does the employee receive commissions? Yes No

If yes, how much did the employee make in commissions in the last 12 calendar months? _____

Claim Information:

Date Employee Last Worked _____

Reason for stopping work: Sickness Granted LOA Laid Off Accident Dismissed
 Resigned Retired Other

Has the employee returned to work? Yes No Part-time Date _____

Full-time Date _____

If No, what is the anticipated return to work date? _____

Provide a brief description of the employee's job duties.

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Applications or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

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 _____

Title _____ Email _____ Date _____

Disability Claim Form Physician Statement: Forza



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Disability Information:

Patient's Name _____ Date of Birth _____ Height _____ Weight _____

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

Date you advised the patient they should cease work: _____

If pregnancy, Estimated Delivery Date: _____ Delivery Date _____ Vaginal Cesarean Section

Estimated date of inception (Conception): _____

For conditions other than pregnancy, the date symptoms first appeared, 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) _____

Diagnosis Code(s) (ICD-9/10) _____ If mental health diagnosis, complete the DSM-IV-TR axis section below:

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

Date Assessed _____

Date of Patient's first visit for this condition _____ Date of last patient visit _____

Frequency of visits: Weekly Monthly Other(specify) _____

Objective findings (including current x-rays, EKG, laboratory data, any clinical findings and complications)

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 program/medications) _____

Have any medications been changed? Yes No If yes, Date changed _____

Medication change: _____

Have any surgeries already been performed? Yes No If yes, Date _____

CPT Code(s)/procedure performed _____

If No, are there any surgeries scheduled? Yes No If yes, Date _____

CPT Codes(s)/procedure scheduled _____

Has the patient been hospital confined? Yes No If yes, Date _____

Discharge Date _____

Hospital Name: _____ Address _____

Has the patient ever had the same of similar condition? Yes No

If yes, indicate the 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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Patient Name _____ Date of Birth _____

Impairment:

Cardiac Functional Capacity Limitations(American Heart Association -if applicable):
 To be completed for cardiac disability

Class 1(none)	Class 2 (slight)
Class 3(marked)	Class 4(complete)

Blood Pressure (Last Visit) _____ Comments _____

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: _____

Mental Impairments (To be completed for Mental Health disabilities)

- 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 on an average working day.

Activity:	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Number of Hours (less than 25%, 50%, 75%, 100%)
Standing					_____
Walking					_____
Sitting					_____
Kneeling					_____
Twisting/bending/stooping					_____
Reaching above shoulder level					_____
Operating heavy machinery					_____
Keyboard Use					_____
Repetitive Hand Motion					_____

	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								
11 to 20lbs								
21 to 50lbs								
51 to 100lbs								

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Patient Name _____ Date of Birth _____

Prognosis and Restrictions:

Is the patient currently disabled from their job? Yes No

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

If yes, please 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? _____ 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 condition/limitations are affecting their ability to work, including any physical restrictions*

*** For pregnancy related disability: If filing disability prior to delivery, please submit medical records and flow charts.**

If terminal, what is the life expectancy:
6 months or less 9 months or less 12 months or less Greater than 12 months

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 11)

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

Printed Name of Physician _____ Phone No. _____

Specialty _____ Tax ID _____

Address _____ City _____

State _____ ZIP Code _____ Fax No. _____

Email Address _____

Signature of Physician

Date

State Specific Fraud Warning Statements

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Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia: Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

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.

Arkansas, Louisiana, 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.

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 statement to appear on this form: Any person who knowingly presents 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: 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

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.

Kentucky, 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.

Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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.

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 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 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.

Virginia: Any person who, with the 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 may have violated the state law.