

# Long Term Disability Claim Statement



## Employer Claim Statement—Part 1 *(Please print or type. If necessary, add separate sheet.)*

New claim:  Yes  No

1. Name of employer _____		2. Policy/participation no. _____		3. Account no. _____	
4. Full name of claimant _____		5. Social Security no. _____	6. Date employed _____	7. Effective date _____	
8. Date last worked _____ Number of hours worked that day _____		9. Work schedule of claimant at time of disability: _____ Days per week _____ Hours per day			
10. Was claimant a member of a union at the time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Was plan effective when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please indicate date of termination _____			
12. Was claimant covered under your prior LTD plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date under <b>prior</b> plan _____ Termination date under <b>prior</b> plan _____					
13. Does claimant have any other coverage(s) with Fortis Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please advise of the type of coverage(s).					
14. Has claimant returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date: _____ With restrictions _____ Full capacity			15. Current work schedule of claimant? _____ Day(s) per week _____ Hours per day		
16. a. Have you and the claimant discussed reasonable accommodations which would allow a return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Do you have an established return to work program? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to either, please explain.  c. What accommodations have you implemented?					
17. Basic monthly earnings \$ _____					
18. How is claimant paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary + Commission <input type="checkbox"/> Salaried <input type="checkbox"/> Commission only <input type="checkbox"/> Salary + Bonus <input type="checkbox"/> Other _____					
19. Does claimant contribute towards the cost of this LTD insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the % paid by: _____ % Claimant _____ % Employer					
20. Are claimant premium contributions made under Section 125 of the Internal Revenue Code? (i.e. a Cafeteria Plan paid with pre-tax dollars) <input type="checkbox"/> Yes <input type="checkbox"/> No					
21. Is there any reason why FICA <b>should not</b> be withheld from the claimant's benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain.					
22. Did this disability occur as a result of the claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed If "Yes," or under dispute, please provide us with the policy no., name, address and phone no. of Workers' Compensation administrator.					
23. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources? <input type="checkbox"/> Salary continuance Amount: _____ per _____ From _____ to _____ <input type="checkbox"/> Workers' Compensation Weekly benefit _____ Effective date _____ <input type="checkbox"/> Retirement or pension Benefit amount _____ Effective date _____ <input type="checkbox"/> Other _____ Lump sum distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No					
24. Remarks _____					
25. Date _____ By _____ FAX AUTHORIZED SIGNATURE/TITLE Fax no. ( _____ ) _____ Phone no. ( _____ ) _____ E-mail address _____					

**Employer Claim Statement—Part 2  
Physical/Non Physical Aspects of Job**

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant's job.

Claimant's occupation \_\_\_\_\_

Signature/Title \_\_\_\_\_

Date \_\_\_\_\_

**Physical Requirements**

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. of Hours	May Alternate Positions			
		At Will	15-30 Minutes	Hourly	Never
Sitting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Driving	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STAPLE YOUR OWN JOB DESCRIPTION HERE

Claimant must	Never	Occasionally (1/4-2 1/2 hours)	Frequently (2 1/2-5 1/2 hours)	Continuously (5 1/2-8 hours)
A. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Enter data/keystroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Lift: Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Carry Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Push/Pull Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.  
 Right:  Yes  No      Left:  Yes  No      Both:  Yes  No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Does job require:

A. Working at unguarded heights?  Yes  No

B. Exposure to marked changes in temperature and humidity or extremes thereof?  Yes  No

C. Exposure to dust, fumes, gases, chemicals?  Yes  No

**Stress/Non Physical**

1. Percentage of time claimant spends answering customer complaints. \_\_\_\_\_ %
2. Percentage of claimant's work primarily judged on production. \_\_\_\_\_ %
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?  
 Yes  No \_\_\_\_\_ % of time
4. How many employees does this claimant supervise? \_\_\_\_\_
5. Is this claimant routinely subject to close supervision?  Yes  No
6. Percentage of time spent by the claimant working with his/her co-workers. \_\_\_\_\_ %
7. Percentage of claimant's time spent on: \_\_\_\_\_ % Prescheduled activities  
 \_\_\_\_\_ % Random activities
8. Percentage of time claimant spends meeting deadlines set by others. \_\_\_\_\_ %
9. Percentage of responsibility the claimant has for the performance of his/her particular department. \_\_\_\_\_ %

**DO NOT DETACH**

**Claimant Statement—Part 1** (Please print or type.)

**Section I**

1. Full name		2. Social Security no.		3. Date of birth	
4. Address (city, state, zip code)				5. Home phone no. ( )	
6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed		8. E-mail address	
		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			
9. Names and birthdates of spouse and all dependent children under age 18.				10. Your occupation	

**Section II**

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred.		2. Date first unable to work because of this disability.	
3. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date: _____ Part-time _____ Full-time If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time			
4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.			
Name		Address	
		Dates of Consultation	
		First Visit Last Visit	
5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.			
Name of Hospital		Address	
		From To	

**Section III**

1. Check if you are receiving or entitled to receive benefits from any of the following sources:

<input type="checkbox"/> Salary, Wages or Commissions	<input type="checkbox"/> Retirement or Pension Plan	<input type="checkbox"/> Railroad Retirement Act
<input type="checkbox"/> State Disability	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other sources
<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Social Security Retirement	

For each source marked above, please provide us with the following information:

Source	Amount of Income		Date Application Filed	Benefit Effective Date
	Amount	Frequency		

**Provide documentation of any source indicated above; i.e. award notices, denial notices or applications.**

2. Do you have medical insurance?  Yes  No Policy no., name, address and phone no. of medical plan administrator.

Please indicate the type of coverage provided (Check all that apply.).

Employer Group  COBRA  Conversion  Individual  Spouse  Government  Other (Specify.) \_\_\_\_\_

**Section IV**

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Fortis Benefits Insurance Company, or its representative, any and all such information. I understand Fortis Benefits Insurance Company may discuss my limitations/restrictions with current or prospective employers as they relate to accommodations and possible return to work. **I UNDERSTAND** the information obtained by use of this Authorization will be used by Fortis Benefits Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT DETACH**

**Claimant Statement—Part 2** *(Do not complete this section if you have returned to work, or if disability is for pregnancy.)*

**Training, Education & Experience**

<p>1. What is your level of education?</p> <p>A. Have you received a high school diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you received the equivalent of a high school diploma (GED)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to either, date earned _____ If "No," please advise us of the last grade completed. _____ grade</p> <p>B. Have you attended college? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some college <input type="checkbox"/> College graduate <input type="checkbox"/> Post graduate Please specify: Major field of study _____ Degree earned _____ Date last attended _____</p> <p>C. Have you attended any trade schools or received any other special training? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: Type of training _____ Date last attended _____</p> <p>D. Do you have any computer skills? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list/describe.</p>
<p>2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.</p>
<p>3. What was your occupation when disability commenced and what were the usual duties of your occupation?</p>
<p>4. Which of the above job duties are you unable to perform?</p>
<p>5. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Have you asked your employer to provide any accommodations which would allow you to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what accommodations did you request and what was your employer's response?</p>
<p>7. What accommodations do you feel could be made by your employer to allow you to return to work?</p>
<p>8. Have you considered retraining? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what vocational area(s) would interest you?</p>
<p>9. Please list any hobbies, outside interests or activities.</p>
<p>10. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name, address and phone number of the counselor handling your case?</p>
<p>11. Have you contacted your state Division of Vocational Rehabilitation Department? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what is the name, address and phone number of the counselor handling your case?</p>
<p>12. Would you like Fortis Benefits' Vocational Rehabilitation Department to contact you to discuss options available which may assist you in returning to gainful employment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

**DO NOT DETACH**



