

Long Term Disability Notice of Claim Package

Employer Notice of Claim - Instructions

At approximately 45 days before end of benefit waiting period:

A. Complete the Employer's Report of Claim in full.

Include:

- Job description (*detailed duties, including physical requirements*)
- Documentation of earnings in accordance with your plan description
- Worker's Compensation information (*copy of first report of accident and the decision if any has been determined at this time*)

B. Give remaining part form to claimant for completion. These forms should be forwarded to the address shown below.

Request:

- Copy of awards from other source of benefits: Social Security, Worker's Compensation, Retirement, State Disability, No-fault auto insurance and any other disability income.
- That the employee forward proof of his/her age.

C. If claimant has more than one treating physician, give claimant additional forms for completion.

D. All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

E. Any questions about these claim filing procedures should be referred to:

GREATER GEORGIA LIFE INSURANCE COMPANY (Greater Georgia Life)
Disability Claim Service Center – LTD Unit
P.O. Box 105426
Atlanta, GA 30348-5426

For Customer Service Call: 800-232-0113
For Customer Service Fax: 800-850-0017

Long Term Disability Claim Form Employer Statement



Employer Statement		
1. Employee's Name	2. Social Security Number	3. Date of birth
4. Street Address	City	State Zip Code
5. Phone Number		
6. Policy Number	7. Certificate Number	8. Billing Unit
9. Class		
10. Employee Date of Hire	11. Effective Date of LTD Coverage	12. Date Employee Last Worked Full-time

Employment	
13. Occupation at time last worked (Attach job description)	14. Work schedule at time last worked # of days per week: _____ # of hours per day: _____
15. Reason for leaving work: <input type="checkbox"/> Sickness <input type="checkbox"/> Granted LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Resigned <input type="checkbox"/> Vacation <input type="checkbox"/> Other	16. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> No Date: _____ Date: _____

Income	
17. How is employee Paid? <input type="checkbox"/> Straight Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Salary & Commission <input type="checkbox"/> Commissions Only <input type="checkbox"/> Salary & Bonus	18. Employee's basic monthly earnings: \$ _____ LTD Benefit _____ (If salary is based on less than 12 months: # of months: _____)
19. Employees percent of LTD premium contribution: Employee pays: _____% Employer pays: _____%	

Other Benefits		
20. Has insured received other disability payments since time last worked?		
Salary Continuance: <input type="checkbox"/> Yes (Weekly amount) _____ Date Benefits Cease: _____	Insured Short Term: <input type="checkbox"/> Yes (Weekly amount) _____ Date Benefits Cease: _____	Other Type: <input type="checkbox"/> Yes (Weekly amount) _____ Date Benefits Cease: _____
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
21. Did claim result from job activity? <input type="checkbox"/> Yes (Explain) _____ <input type="checkbox"/> No	22. Has Worker's Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> Denied (Enclose copy) <input type="checkbox"/> Pending	23. Worker's Compensation weekly amount: \$ _____ (Include copy of 1 st report of accident)

Retirement	
24. Is employee covered by sponsored retirement plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Does retirement plan contain a disability provision? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. Is employee or will this employee be eligible for a disability or retirement pension? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes," type: <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other: _____	
Monthly amount: \$ _____ Date Benefits commence (mm/dd/yyyy): _____	
Note: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his / her contribution to the total contribution.	

Certification		
27. Employer's Name	28. Employer's Telephone Number	29. Certificate Number
30. Employer's Address		
31. Employer (Taxpayer) I.D. Number (EIN): _____ - _____ OR 32. Public Employer Social Security Number: _____ - _____		
33. Name of Authorized Representative (Please print)		34. Signature of Authorized Company Representative
35. Title		36. Date

Separate and send this form (with other enclosures) to the address shown on the front page. Give the remaining forms to the claimant.

The laws of some states require us to provide you with the following information:

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.

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.

Arkansas, Louisiana, and 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.

California: For your protection California 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 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 and Idaho: 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 containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing 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.

Maine, Tennessee, Virginia, and 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 may include imprisonment, fines or denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps to 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 N.H. Rev. Stat. Ann. §638:20.

New Jersey: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: A 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 materials 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 violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and 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.

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.

Long Term Disability Claim Form Employee Statement (continued)



Income

29. Describe other income you are receiving:

YES	NO		Amount	Date Began	Date Terminated
<input type="checkbox"/>	<input type="checkbox"/>	Social Security (disability or retirement)	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	State disability	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Retirement (normal, early or disability)	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Group Disability benefits	\$ _____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____

Benefits

30. Have you, or do you plan to apply for any benefits described above? Yes No

Type: _____ Date application filed: _____

Type: _____ Date application filed: _____

31. If your request for benefits is approved do you want us to withhold amount from each benefit check for federal income tax purposes? Yes No

If "Yes," what amount? \$ _____ (Indicate amount per month, \$88.00 minimum)

32. If your request for benefits is approved do you want us to withhold amounts from each benefit check for state tax purposes? Yes No

If "Yes," what amount? \$ _____ (Indicate amount per month, \$88.00 minimum)

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false or misleading information may be subject to criminal penalties.

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

Signature of Employee

Date



Long Term Disability Employee Authorization for Release of Information



Authorization to be completed by claimant

**AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)**

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Greater Georgia Life Insurance Company (Greater Georgia Life) and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Greater Georgia Life representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Greater Georgia Life solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Greater Georgia Life in writing, of my revocation. However, such revocation is not effective to the extent that Greater Georgia Life have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Greater Georgia Life's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING GREATER GEORGIA LIFE to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and GREATER GEORGIA LIFE shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant's Signature 		Date
Claimant's Name (print or type)		Date of Birth
Relationship of Authorized Person	Description of Personal Representative's Authority, if applicable (If signed by authorized representative, attach verification of identity.)	

Send Completed Form To:
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Long Term Disability Claim Form Attending Physician's Statement



History		
Patient Name		Date of Birth
When did symptoms first appear or accident happen?	Date patient ceased work because of disability?	Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," state when and describe
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Names and addresses of other treating physicians	
Diagnosis (If disabling condition is due to a mental or nervous disorder, the attached Functional Capabilities and Mental Status Supplemental Questionnaire must also be completed.)		
Diagnosis (including complications):	If pregnancy, estimated date of delivery:	Subjective symptoms:
Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings):		
Treatment		
Date of first visit:	Date of last visit:	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)
Nature of treatment (including surgery and medications prescribed, if any):		
Progress		
Has patient: <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?	Is patient: <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?	Is patient mentally competent to endorse checks and direct proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient been hospital confined (If yes, please give the name and address of the hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from: _____ through _____		
Cardiac		
Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 (No limitations) <input type="checkbox"/> Class 2 (Slight limitations) <input type="checkbox"/> Class 3 (Marked limitations) <input type="checkbox"/> Class 4 (Complete limitations)	Blood Pressure (last year) _____ (systolic/diastolic)	
Impairments		
Physical impairments (*As defined in Federal Dictionary of Occupational Titles.) <input type="checkbox"/> Class 1 - No limitations of functional capacity; capable of heavy work* no restrictions, (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity* (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical / administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)		
Remarks:		

Long Term Disability Claim Form

Attending Physician's Statement (continued)



Impairments(continued)			
Mental Impairments (if any):			
(a) Please define "stress" as it applies to this claimant and in light of his/her job requirements.			
(b) What stress and problems in interpersonal relations has claimant had on job?			
<input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (<i>no limitations</i>) <input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (<i>slight limitations</i>) <input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (<i>moderate limitations</i>) <input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (<i>marked limitations</i>) <input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological personal and social adjustment (<i>severe limitations</i>)			
Prognosis			
Is patient now totally disabled? (<i>unable to be gainfully employed</i>)		Date patient became disabled due to present illness	
Patient's Job: <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work: <input type="checkbox"/> Yes <input type="checkbox"/> No			
When do you expect a fundamental or marked change in the future?			
<input type="checkbox"/> 1 Mo. <input type="checkbox"/> 1-3 Mos. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> Never		Applies to: <input type="checkbox"/> Patient's Job <input type="checkbox"/> Other work	
Rehab			
I patient a suitable candidate for occupational rehabilitation?		Can present job be modified to allow for handling with impairment?	
Patient's own job? <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
When could trial employment commence?			
Patient's Job?		Any other work?	
Date: _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Date: _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Remarks			
Limitations, therapy, etc.:			
Name of Attending Physician (Please type or print)		Degree	Telephone
Street address	City or Town	State or Province	Zip Code
Signature			Date
▶			

Long Term Disability Claim Form Supplemental Attending Physician's Statement



Mental Status Questionnaire
(Only needs to be completed if condition is due to mental or nervous disorder.)

Patient Name

Date treatment began: (mm/dd/yyyy)	Continuing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Terminated (mm/dd/yyyy)
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Diagnosis (Use DSM III Multi-axial evaluation nomenclature and code numbers)

I
II
III
IV
V

Please respond to all items. Use additional pages as necessary.

State patient's initial reason for seeking treatment. Describe how and when the condition was first manifested. Summarize previous treatment testing. If any.

Describe patient's current condition and mental status. Include the duration and severity impairments and stress factors.

Medications: Please list current medications, dosage and dates begun, as well as existing or possible side effects.

Duration and Treatments: Please summarize current treatment goals and estimated duration of treatment to achieve stated goals.

Comments:

Long Term Disability Claim Form Supplemental Attending Physician's Statement (continued)



Functional Capacities Evaluation

Based on your evaluation of the claimant's psychiatric status, please give your opinion as to the extent of the claimant's ability to do the following on a **sustained** basis.

None: No impairment in this area.

Mild: Suspected impairment of slight importance which does not affect functionality ability.

Moderate: Impairment affects but does not preclude ability to function.

Moderately Severe: Impairment significantly affects ability to function.

Severe: Extreme impairment of ability to function.

1	Ability to relate to other people.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
2	Restriction of daily activities, e.g. ability to attend meetings, socialize with others, attend to personal needs, etc.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
3	Deterioration of personal habits.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
4	Constriction of interests	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
5	Understand, carry out, and remember instructions.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
6	Respond appropriately to supervision.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
7	Perform work requiring regular contact with others.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
8	Perform work where contact with others will be minimal.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
9	Perform tasks involving minimal intellectual effort.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
10	Perform intellectually complex tasks requiring higher levels of reasoning, math and language skills.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
11	Perform repetitive tasks.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
12	Perform varied tasks.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
13	Makes independent judgments.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
14	Supervise or manage others.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe
15	Perform under stress when confronted with emergency, critical, unusual or dangerous situations; or situations in which working speed and sustained attention are make or break aspects of the job.	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> Severe

Physician's Signature

Date

Greater Georgia Insurance Company, Disability Claims Service Center
P.O. Box 105426, Atlanta, GA 30348-5426

Phone: 800-232-0113

Fax: 800-850-0017