

Phone Number: (877) 949-7226

## INSTRUCTIONS

A Waiver of Premium claim should be filed for an eligible insured who has been continuously disabled for the length of time indicated in the policy (the waiver elimination period - usually six or nine months). However, the claim may be submitted prior to that time if it can be presumed that the employee will remain continuously disabled for the required amount of time.

Premium must continue to be paid during the waiver elimination period.

To be eligible for Waiver of Premium, the eligible employee must be under the age of sixty, or age specified in the policy, on the date their disability begins.

**Please Note: Proof of disability must be received within one year of the start of the disability.**

Please submit the following documentation:

1. Claim Form:

Part 1 – Completed by the Employer/Administrator

Part 2 - Completed by the Insured, or if deceased, by his/her Spouse, Registered Domestic Partner or Legal Representative.

Part 3 – Completed by the Attending Physician (insured is responsible for any costs)

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.

3. If the benefits are based on salary, submit payroll records verifying the employee's annual earnings at the time of their disability.

4. If any portion of coverage is paid for by the employee, submit proof of payroll deduction.

5. The insured person is responsible for any costs associated with completion of the Attending Physician Statement.

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Nexben is an independent organization that does not provide Dearborn Life Insurance Company, Blue Cross Blue Shield of Michigan or Specialty Benefits products or services.

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**Part 1 - To be completed by Employer/Administrator**

**Statement of Employer**

Employer/Plan Information

Group Name \_\_\_\_\_ Subsidiary Name \_\_\_\_\_

Group Number \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Name and Title of Authorized Representative \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Insured Person Information

Name of Claimant \_\_\_\_\_  
Last First Middle

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Hire Date \_\_\_\_\_ Insurance Effective Date \_\_\_\_\_ Occupation \_\_\_\_\_

Annual Salary \_\_\_\_\_ Date of Last Salary Increase \_\_\_\_\_

Amount of Insurance: Basic Life \_\_\_\_\_

Supplemental Life \_\_\_\_\_

Voluntary Life \_\_\_\_\_

Last Day Worked \_\_\_\_\_ Reason for cessation of work \_\_\_\_\_

Provide date of disability \_\_\_\_\_

Date of Last Premium Contribution: Group \_\_\_\_\_ Member \_\_\_\_\_

**If the eligible insured is deceased provide proof that he/she died within one year from the date of becoming Totally Disabled, and remained Totally Disabled until the date of death.**

**I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.**

Signature of Authorized Employer/Plan Representative \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

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**Part 2 - To be completed by Insured or if deceased, by his/her Spouse, Registered Domestic Partner or Legal Representative.**

Name: \_\_\_\_\_  
Last First Middle

Maiden Name \_\_\_\_\_ Alias Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Are you a U.S. Citizen:  Yes  No (If No - IRS Form W-8 required)

Date of Accident or beginning of sickness \_\_\_\_\_

If Injury, describe how, when and where accident occurred: \_\_\_\_\_

If Illness, have you ever had same or similar illness:  Yes  No If yes, give dates: \_\_\_\_\_

Name of Employer \_\_\_\_\_ Last day worked \_\_\_\_\_

Occupation \_\_\_\_\_

Between what dates were you unable to perform any duties \_\_\_\_\_

Name of Treating Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Location of Hospital: \_\_\_\_\_  
Street City State Zip

Hospital Phone Number \_\_\_\_\_

Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_

**Certification**

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Your Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

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### Part 3 - Attending Physician's Statement

(Insured is responsible for any costs associated with completion of the Attending Physician's Statement)

Name of Patient: \_\_\_\_\_  
Last First Middle

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Date of Accident or appearance of symptoms \_\_\_\_\_

Date First Consulted \_\_\_\_\_ Date of Total Disability Diagnosis \_\_\_\_\_

Date of Permanent Disability Diagnosis \_\_\_\_\_

Has patient ever had same or similar conditions \_\_\_\_\_

Is the disability the result of an accident:  Yes  No

If Yes, Please list any co-morbid conditions contributing to the disability:

Diagnosis/ICD 9/10 \_\_\_\_\_

Is patient still under your care:  Yes  No Last Date of Treatment \_\_\_\_\_

Patient can return to work on \_\_\_\_\_ Full-Time  Yes  No Part-Time  Yes  No  
# of hrs per day \_\_\_\_\_ Week \_\_\_\_\_

Patient disabled (unable to work) Own Occupation \_\_\_\_\_ Any Occupation \_\_\_\_\_

Patient disabled (unable to work) Own Occupation \_\_\_\_\_ Any Occupation \_\_\_\_\_

Symptoms \_\_\_\_\_

Treatment \_\_\_\_\_

Medications \_\_\_\_\_

Limitations/Restrictions \_\_\_\_\_

Specialist Referral to \_\_\_\_\_

Physician Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ EIN/SSN \_\_\_\_\_

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

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## AGREEMENTS AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize my employer to disclose all information necessary to process my claim to Dearborn Life Insurance Company (The Company).

I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn Life Insurance Company's claim department or its authorized representative(s) information about my medical history or treatment and/or furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse and mental illness. I further authorize Dearborn Life Insurance Company to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

This authorization shall expire on the date that I received notice of Dearborn Life Insurance Company's final decision on my claim. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by Dearborn Life Insurance Company prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy rule;
- I should retain a copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from Dearborn Life Insurance Company.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, Dearborn Life Insurance Company has the right to deny my claim.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Claimant/Legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured or personal/legal representative signing for Claimant/Insured:

Address: \_\_\_\_\_  
Street City State Zip

Phone No. \_\_\_\_\_

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The laws of some states require us to furnish you with the following notice:

**FOR APPLICATIONS AND CLAIMS:**

**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.

**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.

**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.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

**Maryland:** Any person who knowingly or willingly 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 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.

**Ohio:** Any person who, with intent to defraud or knowingly 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:** 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 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 with the penalty of 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.

**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 application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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**The laws of some states require us to furnish you with the following notice:****FOR CLAIMS ONLY:**

**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:** 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.

**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.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing 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.

**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 NH 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.

**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.

**FOR APPLICATIONS ONLY:**

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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