Specialty Benefits

Group Products
Underwritten by Dearborn Life Insurance Company

Group Long-Term Disability Claim Form

Return to SBAM at:
MemberCare@sbam.org
101 S Washington Square, Suite 900
Lansing, MI 48933

Phone Number: (877)-949-7226

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

NOTICE OF CLAIM - Employer Instructions

Approximately 6 to 8 weeks before the end of the elimination period:

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

B. Give claim form to claimant for completion; and

C. Request copy of awards from other sources of benefits: Social Security, Workers' Compensation, retirement, state disability, and others.

When claimant returns the form to you:

A. Attach:

- Job description (detailed duties)
- Proof of enrollment (only for contributory coverage)
- Documentation of earnings if other than straight salary
- If Workers' Compensation claim filed, include copy of First Report of Accident and the decision

B. Return, together with all attachments, to Dearborn Life Insurance Company at the address shown above.

APPLICATION FOR LTD BENEFITS - Employee Instructions

A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Dearborn Life Insurance Company or its representative to secure additional information if necessary to make a decision on your claim.

B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

A. Attach a copy of Social Security and other income entitlement awards; and

B. Return to your employer.

Electronic Funds Transfer (EFT) Authorization

If you are eligible for monthly benefits, and wish to receive benefits via direct deposit, complete the attached form and return as indicated.

APPLICATION FOR LTD BENEFITS - Physician Instructions

As soon as the claimant gives you this form:

A. Complete the APS on page 4 of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.

B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

R010122 | Z4643_BCBSM

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Employer Report Of Claim

To be Completed by Employer

CLAIMANT

1. Employee Name (Last) (First) (M.I.) | 2. Social Security No. | 3. Date of Birth

4. Address | City | State | Zip Code

EMPLOYMENT

5. Insurance Class | 6. Employee Date of Hire | 7. Date Employee Became Insured for LTD | 8. Date Employee was actually last present at work

9. Occupation at Time Last Worked (attach job description)

10. Work Schedule at Time Last Worked
No. of Days Per Week _____ No. of Hours Per Day _____

11. Reason for stopping: Date _____
☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Resigned
☐ Retired ☐ Dismissed ☐ Other ☐ Vacation

12. Has Employee Returned to Work: ☐ Yes ☐ No
If Yes: ☐ Part-Time ☐ Full-Time
Date _____ Date _____

INCOME

13. How is Employee Paid:
☐ Straight Salary ☐ Hourly Commissions Only
☐ Salary & Commission ☐ Salary & Bonus

14 Employee's Basic Monthly Earnings
$ _____ LTD Benefit _____

Does the Employee contribute towards the cost of this LTD insurance: ☐ yes ☐ no If "Yes,": ☐ Pre-Tax ☐ Post-Tax
If "Post-tax," _____ % premium dollars paid by employer, _____ % paid by claimant.
See IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for more information on calculating the taxable percentage.

OTHER BENEFITS

16. Has the Insured Received Other Disability Payments Since Time Last Worked

Salary Continuation:
☐ Yes Wkly. Amt. $ _____
Date Benefits Cease _____
☐ No

Short Term Disability:
☐ Yes Wkly. Amt. $ _____
Date Benefits Cease _____
☐ No

Sick Leave:
☐ Yes Wkly. Amt. $ _____
Date Benefits Cease _____
☐ No

17. Did Claim Result From Job Activity:
☐ Yes Explain _____
☐ No

18. Has Workers' Compensation claim been filed:
Yes (Enclose copy of 1st report of accident
No
Pending
Denied (Enclose copy of denial)

19. Workers' Comp. Weekly Amount:
$ _____

RETIREMENT

20. Is Employee Covered by Employer Sponsored Retirement Plan: ☐ Yes ☐ No

21. Does Retirement Plan Contain a Disability Provision: ☐ Yes ☐ No

22. Is Employee or will Employee be Eligible for a Disability or Retirement Pension:
☐ Yes If Yes: Disability
Retirement
Other _____
☐ No
Monthly Amt. $ _____
Commence Date of Benefits _____
(Please Enclose Copy of Summary Plan Description)

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

23. Employer Name (association and policyholder, if other) | 24. Telephone No. | 25. Group Policy No.

26. Address | City | State | Zip Code

27. Employer (Taxpayer) I.D. Number (EIN) _____
OR
28. Public Employer Social Security No. 69 _____

29. Name of Person Completing this Form (Printed)

30. Signature of Authorized Insurance Representative | Title | Date

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Employee Claim Statement

To be Completed by Employee

CLAIMANT

1. Full Name (Last) (First) (M.I.)
2. Maiden Name
3. Alias Name
4. Social Security No.
5. Phone Number
6. Date of Birth
7. Height ___ ft. - ___ in.
8. Weight ___ lbs.
9. Sex ☐ Male ☐ Female
10. Address
City State Zip Code
11. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
12. Spouse's Date of Birth ___ First Name ___
13. Is Spouse Employed ☐ Yes ☐ No
14. Number of Children (Under age 19)
15. List Names and DOB of unmarried children in high school

EMPLOYMENT

16. Employer Name
17. Group Policy No.
18. Occupation (List the duties of your occupation at the time of disability)
19. Accident or first noticed symptoms of illness on
20. I have been unable to work due to the disability since
21. I returned to work on a part-time basis on
22. I returned to work on a full-time basis on
23. Is Your Accident or Illness Related to Your Occupation: ☐ Yes ☐ No Explain ___
24. Have You or do You Intend to File a Workers' Comp Claim: ☐ Yes ☐ No

CLAIM HISTORY

25. Describe How and Where the Accident Occurred or Describe the Onset and Nature of Your Illness
26. Date You Were First Treated for Illness/Injury
27. Treated By
Hospital Name / Street Address / City / State / Zip
Doctor Name / Street Address / City / State / Zip
28. Have You had the Same or Similar Condition Before
29. Treated By
Hospital Name / Street Address / City / State / Zip
Doctor Name / Street Address / City / State / Zip

OTHER INCOME

30. Describe Other Income You are Receiving

			Amount	Date Began	Term.
☐ Yes	☐ No	Social Security (disability or retirement)	$		
☐ Yes	☐ No	State Disability	$		
☐ Yes	☐ No	Retirement (normal, early, or disability)	$		
☐ Yes	☐ No	Workers' Compensation	$		
☐ Yes	☐ No	Group Disability Benefits	$		
☐ Yes	☐ No	Other (describe) ___	$		

31. Have You Applied, or do You Plan to Apply for Benefits Described Above: ☐ Yes ☐ No
Type ___ Date Application Filed ___
Type ___ Date Application Filed ___
32. If Your Request for Benefits is Approved, do You want Us to Withhold Amounts from each Benefit for Federal Income Tax Purposes: ☐ Yes ☐ No If Yes, Please Complete and Attach IRS Form W4S.

AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Dearborn Life Insurance Company's claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to 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, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim. This authorization expires on the date I receive notice of Dearborn Life Insurance Company's final claim decision. I may revoke this authorization at any time, but 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. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a 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 of Employee ___ Date ___

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Attending Physician Statement

Name of Patient (Last)	(First)	(M.I.)	Date of Birth	*Please submit bill for records with this claim.

HISTORY

(a) When did symptoms first appear or accident happen

(b) Date patient ceased work because of disability

(c) Has patient ever had same or similar condition ☐ Yes ☐ No If Yes, state when and describe

(d) Is condition due to injury or sickness arising out of patient's employment ☐ Yes ☐ No ☐ Unknown

(e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (including complications) Please submit all office notes regarding this condition*

(b) Subjective symptoms

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

TREATMENT

(a) Date of first visit

(b) Date of last visit

(c) Frequency ☐ Monthly ☐ Weekly ☐ Other

(d) Nature of treatment (including surgery and medications prescribed, if any)

PROGRESS

(a) Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

(b) Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital confined

(c) Has patient been hospital confined ☐ Yes ☐ No Confined from _____ through _____

If, yes, give hospital name and address

CARDIAC

(a) Functional capacity (American Heart Ass'n.)
☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

(b) Blood Pressure (last visit) _____ systolic/diastolic

IMPAIRMENT

(a) Physical impairments (*as defined in Federal Dictionary of Occupational Titles)

Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions (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; incapable of minimum (sedentary*) activity (75-100%)

Remarks

(b) Mental Impairments (if applicable)
(a) Please define "stress" as it applies to this claimant
(b) What stress and problems in interpersonal relations has claimant had on job

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 most interpersonal relations (slight limitations)
Class 3 - Patient is able to engage in only limited stress situations and engage in only 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)

Remarks

PROGNOSIS

(a) Is patient now totally disabled Patient's job: ☐ Yes ☐ No Any other work: ☐ Yes ☐ No

(b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future:
1 Mo | 1-3 Mo | 3-6 Mo | Never Applies To: ☐ Patient's job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation Patient's job: ☐ Yes ☐ No Any other work: ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment: ☐ Yes ☐ No

(c) When could trial employment commence Date _____ ☐ Full-time ☐ Part-time Patient's job: Date _____ ☐ Full-time ☐ Part-time Patient's job:

REMARKS

(Limitations, Therapy, etc.)

Name (Attending Physician) (Last)	(First)	Degree	Telephone / Fax#

Address	City	State	Zip

Signature	Date

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DIRECT DEPOSIT AUTHORIZATION AGREEMENT

☐ New Direct Deposit ☐ Cancel Direct Deposit ☐ Change to Current Direct Deposit

Please Print		
Name:	Social Security Number:	Claim Number if known:

Fill out either the Checking Account Information Section or the Savings Account/Credit Union Information Section.
You may indicate **one account only**.

Checking Account Information

Obtain this information directly from the bottom of your check or from your financial institution.

Name of Financial Institution:
Address of Financial Institution:

Routing Number (first number on bottom left of check):	Account Number (second number on bottom of check):

Savings Account/Credit Union Information

Obtain this information from your financial institution.
The information on your deposit slip is **not** applicable for this purpose.

Name of Financial Institution:
Address of Financial Institution:

Routing Number (first number on bottom left of check):	Account Number (second number on bottom of check):

Authorization

I hereby authorize the company to initiate credit entries and if necessary, debit entries and adjustments for any credit entries made in error to my account, with the financial institution indicated. The financial institution is authorized by me to credit or debit my account for the amount of those entries.

This authorization is to remain in effect until the company has received written notification from me of its termination in such time and in such manner as to afford the company a reasonable opportunity to act on it.

Signature:	Date:

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MemberCare@sbam.org
101 S Washington Square, Suite 900
Lansing, MI 48933

R010122 | Z6501_BCBSM

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Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

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.

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

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.