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Disability Insurance Specialists, LLC
PO Box 25, Bloomfield, CT 06002
(800) 722-9680
(860) 761-1830
www.dispec.com

APPLICATION FOR CONTINUED LIFE INSURANCE COVERAGE UNDER WAIVER OF PREMIUM

EMPLOYER'S STATEMENT

This statement must be fully answered by the Employer / Policyholder.

1. Employer's / Policyholder's Name:	Policy No.
2. Address:	
3. Employee's Name	4. Social Security Number
5. Date of Birth	6. Date of Hire
7. Last Day of Work:	8. Employee's Occupation
9. Date Life Insurance Coverage Began	10. Date Through Which Premiums Were Paid
11. Status of Employee? Active ☐ Terminated ☐	Date of termination if applicable:

12. Life Insurance Coverages:

Coverage Type	Coverage Amount	Policy Number
Basic		
Supplemental		
Dependent		

13. Please attach a copy of the Employee's enrollment form and Beneficiary Designation.

14. Employee's Earnings as of last day of work: $ Annually Monthly Weekly

Employer's Authorized Representative Name:_____

Telephone Number:_____

Date: _____

Please review the applicable anti-fraud statements on the reverse side of this form.

Anti-Fraud Statements

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines, and denial of benefits.

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 to appear on this form: 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.

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 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 guilt of a felony of the third degree.

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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insured: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 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.

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 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 state value of the claim for each such violation.

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ATTENDING PHYSICIAN'S STATEMENT

Patient: XXXX **Date of Birth: XXXXX** **Social Security Number: XXXXX**

Patient's Height. _____Weight _____ BP _____ Pulse (radial)_____
Date symptoms first appeared _____ Date of most recent visit _____
If patient was hospitalized, please provide dates: Admitted _____ Discharged _____
Admitting Diagnosis: _____ Name of Hospital: _____

DIAGNOSIS
1. Primary Diagnosis:_____**ICD-9 Code** _____

2. Secondary Diagnosis:_____ **ICD-9 Code**_____
Other Diagnoses related to this claim: _____
Symptoms:_____ Objective findings: _____
Treatment Plan: _____

LEVEL OF FUNCTIONAL IMPAIRMENT
In a normal work day allowing for 2 breaks and a meal break, the patient can:
Lift (in pounds) [ ] 1-10 [ ] 11-20 [ ] 21 –50 [ ] 51 – 75 [ ] 76+
Carry in pound [ ] 1-10 [ ] 11-20 [ ] 21 –50 [ ] 51 – 75 [ ] 76+

Sit (hours per day)	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Bend / stoop [ ] Never [ ] Occasionally [ ] Frequently

Progress: Has the patient [ ] - Recovered [ ] -Improved [ ] -Unchanged [ ]- Retrogressed
Is the patient: [ ] - Ambulatory [ ]- House confined [ ]- Bed confined [ ]- Hospital confined

CARDIAC (if applicable) America Heart Association functional capacity
[ ]-class 1 no limitation [ ]-class 2 slight limitation [ ]-class 3 marked limitation [ ]-class 4 complete limitation

PHYSICAL IMPAIRMENT
[ ] class 1 – no limitation in functional capacity / capable of heavy work.
[ ] class 2 – medium manual activity.
[ ] class 3 – slight limitation of functional capacity, capable of light work
[ ] class 4 - moderate limitation of functional capacity, capable of clerical / administrative (sedentary) work.
[ ] class 5 – severe limitation of functional capacity, incapable of minimal (sedentary) work.

MENTAL/NERVOUS IMPAIRMENT (if applicable)
[ ] class 1 – Patient is able to engage in 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.
[ ] class 3 – Patient is only able to engage in limited stress situations and limited interpersonal relations.
[ ] class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
[ ] class 5 – Patient has significant loss of psychological, physiological and social adjustment (severe limitation)

Prognosis: Do you expect a fundamental or marked change in the future? _____

Some states require this statement on claim forms: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. In Florida and other states fraud is a felony.

Physician's Signature _____Date _____

Physician's Name _____ Specialty _____
Address_____
City:_____State:_____Zip:_____
Phone No:_____Fax:_____

CONTINUANCE OF TOTAL DISABILITY

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Policy Number: XXX Claim Number XXXX

CLAIMANT'S STATEMENT

AS REQUIRED BY LAW, 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.

This statement must be fully answered by the insured or his/her duly appointed Guardian or committee if incompetent or totally incapacitated. If there be no Guardian or committee, the statement may be executed by beneficiary or insured's nearest relative.

1. Full Name of insured: XXX XXXX

2. Present address XXXX XXXX

3. If confined to a hospital, sanitarium, or other institution, give it's name and address

4. Is the insured confined to his/her bed or home? Yes ☐ No ☐. If Yes, state which and from what date

5. If not confined, how does insured spend his/her time?

6. Fully described insured's present condition and state how and to what extent he/she is unable to follow any occupation for remuneration or profit.

7. Is condition showing improvement? Yes ☐ No ☐ (Give Full Particulars):

8. Give the name and address of every physician or practitioner in attendance or consulted:

Duration	Name of Physician or practitioner	Address

9. Who was insured's last employer? (Give Name & Address):

10 Is insured's position being held open for him/her?

11. Has insured done any kind of work since commencement of present disability? If so, give full particulars & dates.

12 When does insured expect to be able to work?

13. Is insured receiving any disability income, allowance or pension from any other source? If so, give name of each company or source of payment with amounts of weekly or monthly payments.

14. Is insured Mentally disabled Yes ☐ No ☐

15. If Yes, when was he/she adjudged incompetent and who was appointed by the court as committee or gaurdian for his/her estate?

TO PHYSICIANS OR PRACTIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORMATION BUREAU, EMPLOYERS AND OTHER PERSONS OR INSTITUTIONS: This authorizes you to give Disability Insurance Specialists, or its authorized representative who is employed to assist in the evaluation of my claim, any information, data or records you have about me or my health, including medical history, diagnosis, prognosis, and treatment of any physical or mental condition, and including information about a psychiatric condition or use of drugs or alcohol Any non-medical information which is requested about me to determine my eligibility for insurance benefits, including such things as my education, employment history, other claims I have filed, and my eligibility for other benefits.

I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE USED TO DETERMINE MY ELIGIBILITY FOR INSURANCE BENEFITS. I understand and agree that this authorization will remain in force throughout the duration of my claim for benefits from Disability Insurance Specialists. I agree that a photocopy of this authorization may be used to obtain information. I understand that additional copies will be provided to me upon request.

I hereby Certify that the answers above are true and complete to the best of my knowledge.

Date _____ Signature _____

Phone Number _____ Address _____

Witness' Signature (required if the claimant is unable to sign and writes an "X")

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

Authorization to Obtain and Disclose Information

I hereby authorize all of the people and organizations listed below to give Disability Insurance Specialists and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize the following entity to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility
- any insurance or reinsurance company (including the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage)
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits and contestability of a health insurance policy.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the XXXX Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: Disability Insurance Specialists P.O. Box 25 Bloomfield, CT 06002. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Name of Insured	Date
Signature of Insured or Insured's Personal Representative	Description of Authority of Personal Representative (if applicable)