EMPLOYEE REQUEST FOR INFORMATION

Aetna Life Insurance Company
Phone 866-282-8495
Fax 877-693-7258

This notice should be completed and mailed to Aetna Life Insurance Company in order to initiate a disability claim. Neither the furnishing of this form, nor its acceptance by the company, shall be construed as an admission of liability or a waiver of any of the provisions of the plan document.

EMPLOYER INFORMATION

Name of Employer				EIN#
Employer Address				
Work Location (if different from the above)				
Supervisor's name and phone number				
Control #	Suffix	Account	STD Plan	LTD Plan
Employee's Name				Employee's SS#
Date of Hire	STD Coverage Effective Date	LTD Coverage Effective Date	Date Last Worked	Was more than a half day completed? ☐Yes ☐No
Employee's Occupation		Occupation is: ☐Sedentary ☐Light ☐Moderate ☐Heavy		Salary continuation was paid through (date)
Reason employee ceased work				
Employee's earnings are: $ ☐ Annually ☐Monthly ☐ Weekly ☐ Hourly			Number of hours per week	
If premium deductions are to be withheld please list the amounts (weekly) Medical $ Life $ Other $		The portion of the cost of coverage that is paid by the employee with post-tax dollars is non- taxable. What percentage of the cost of coverage is paid by the employee in this manner? STD % LTD %		

The following is applicable only if the employee also has group life insurance with Aetna:

Amount of Life Insurance Coverage
Basic $
Supplemental $

Type of Disability Coverage included with Life insurance
☐ DBO-AID ☐ PTD
☐ SIB-PW ☐ Premium Waiver

Name and phone number of person providing the above information:	Date:

EMPLOYEE INFORMATION

Employee's Address			
Phone number		May we leave messages on your answering machine? ☐Yes ☐No	Date of birth
Date of Hire	Date Last Worked	Date first missed work due to disability	Date returned/will return to work
What is the nature of your disability (diagnosis and/or ICD/CPT Code)?		Were you hospitalized due to this condition? ☐Yes ☐No If yes, what date were you hospitalized on?	
Is this condition work related? ☐Yes ☐No	Is this condition the result of an accident? ☐Yes ☐No	Is this condition the result of a motor vehicle accident? ☐Yes ☐No	
What is your occupation?		Briefly describe your job duties	
What is your doctor's name?		What is your doctor's address and phone number?	
Has your doctor recommended that you stay out of work because you cannot perform your job at this time? ☐Yes ☐No If so, how long do they expect you to remain out of work?			
Briefly describe how your condition prevents you from working			
Have you been disabled as a result of this condition before? ☐Yes ☐No If so, when and how long?		Is there any other information you would like to add/we should be aware of	

By furnishing this blank and investigating the claim, Aetna shall not be held to admit the validity of any claim or waive the breach of any condition of the policy or contract. For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents: Any insurer or agent who knowingly provides false or misleading information must be reported to the Insurance Division.**

Employee Signature ______________________ Date ____________

Mail this completed form to: Aetna Disability Services
Disability Claim Intake
P.O. Box 1460
Portland, OR 97207