Madison National Life

Insurance Company, Inc.

P.O. BOX 5008, MADISON, WI 53705
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

EMPLOYEE'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurer we are committed to assisting you in a return to health and to productive employment. Please complete the following form as thoroughly as possible. By accepting forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights and / or defenses. Any incomplete claim form will not be accepted. We highly recommend that you also provide medical records from each of your treating physicians to help expedite the review of your claim. Lack of medical records may result in a delay in the review of your claim.

BACKGROUND INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ Short Term Disability benefits ☐ Long Term Disability benefits ☐ Life Insurance Waiver of Premium benefits

Name (print): _____ Social security number: _____

Address: _____ Telephone number: _____

City: _____ State: _____ Zip: _____ Email address: _____

Date of birth: _____ ☐ Male ☐ Female Height: _____ Weight: _____ ☐ Single ☐ Married

Name and birth date of spouse and all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school or (3) disabled children regardless of age if their disability began before age 22):

_____

_____

Your employer's name: _____ Occupation/Job title: _____

Date of hire: _____ Annual salary: _____

Please indicate the extent of your formal education (*circle one*)

Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School

If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*):

Job title:	Duties:	Years worked:
(a)		
(b)		
(c)		
(d)		

CLAIM INFORMATION

Is your claim related to an accident or injury? ☐ No ☐ Yes If yes, date and time of accident or injury: _____

Describe how and where the accident or injury occurred: _____

_____

Is your claim related to your occupation? ☐ No ☐ Yes If yes, have you filed a Worker's Compensation claim? ☐ No ☐ Yes

If you have filed a Workers' Compensation Claim, please indicate the status of your claim as well as your weekly benefit amount if your claim has been approved: _____

If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation Services? ☐ No ☐ Yes ☐ My Workers' Compensation claim is currently being disputed

Is your claim related to an illness ☐ No ☐ Yes If yes, Date symptoms first appeared: _____

Please list all symptoms associated with your claim: _____

_____

Date you ceased work: _____ Have you returned to work? ☐ No ☐ Yes If yes, date returned: _____ ☐ Full-time ☐ Part-time

If you have returned to work part time please indicate the number of hours: _____ per day _____ days per week

Continued on Reverse Side

Name_____ DOB#_____

CLAIM INFORMATION CONTINUED

When do you plan to return to your job either on a full-time or part-time basis? Please explain in detail: _____

Please describe the primary tasks of your occupation: _____

Has your doctor provided work restrictions? ☐ No ☐ Yes If yes, please describe: _____

Can you return to your job or another job with your current employer if accommodations were made? ☐ No ☐ Yes If yes, please describe the accommodation needs: _____

Are there any concerns you have about returning to work? ☐ No ☐ Yes If yes, please describe: _____

MEDICAL INFORMATION

Please provide us with a brief description of your condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work: _____

Date first treated for this condition: _____ Name of physician that provided initial treatment: _____

Have you ever had the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of doctor:

Name Street Address

City State Zip Phone

Have you ever been hospitalized for the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of hospital:

Name Street Address

City State Zip Phone

If claim is related to Pregnancy: Expected date of delivery:_____ Actual Date of Delivery:_____ ☐Vaginal ☐C-Section

Were / are there any complications associated with your pregnancy? ☐ No ☐ Yes If yes, please describe: _____

OTHER INCOME BENEFITS / FEDERAL TAXES

Your monthly benefit may be affected by other income benefits received. We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ No	☐ Yes	Social Security Disability or Retirement	☐ No	☐ Yes	Unemployment Benefits	☐ No	☐ Yes
Vacation/Bonus Pay	☐ No	☐ Yes	Retirement Benefits	☐ No	☐ Yes	Other Income Benefits	☐ No	☐ Yes
Automobile No-Fault	☐ No	☐ Yes	Short Term Disability	☐ No	☐ Yes	Workers' Compensation	☐ No	☐ Yes

If you have been awarded any of the above other income benefits, please list the type of benefit, benefit amount, frequency of payment, and benefit effective date:

Have you tried any type of other work since the date your ceased work, as noted above? (either for this employer, another employer or through self-employment) ☐ No ☐ Yes if yes, provide name and address of employer, type of work, when employment began and number of hours worked per week: _____

If your employer pays any portion of the premium or premiums are withheld from your pay on a pre-tax basis, you may elect to have Federal Income Tax withheld from each payment. Federal Tax withholding is not mandatory. Do you want amounts withheld for Federal Tax Purposes? ☐No ☐Yes, If Yes you must indicate a dollar amount or percentage that you would like to have withheld from your benefit payment: _____

The information I have provided on this form is accurate to the best of my knowledge.

Signature _____ **Date**_____

Fraud Warnings

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COLORADO WARNING: 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 damage. 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.

FLORIDA WARNING: 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 guilty of a felony of the third degree.

KENTUCKY WARNING: 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 HAMPSHIRE WARNING: 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 RSA 638:20.

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NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

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

PENNSYLVANIA WARNING: 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.

WASHINGTON WARNING: 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.

Signature _____ **Date** _____

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Patient Authorization to Release Protected Medical Information

Lack of completion of this form may result in a delay in the review of your claim. Please complete this form in detail to assist us in providing a timely review of your application for benefits.

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Physician / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical record department fax number: _____ Date Last treated: _____

2) Physician / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical record department fax number: _____ Date Last treated: _____

3) Physician / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical record department fax number: _____ Date Last treated: _____

4) Physician / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical record department fax number: _____ Date Last treated: _____

5) Physician / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical record department fax number: _____ Date Last treated: _____

to:

Madison National Life
P.O Box 5008
Madison, WI 53705
(800) 356-9601 Extension 2410
Fax: (608) 830-2701

I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the clinic(s) listed above. This authorization will remain valid for one full year from the date of my signature.

The information released:

- Medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2007 through one year from the date of this form.
- Psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2007 through one year from the date of this form.

I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is as valid as the original. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining my authorization.
I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by Madison National Life Insurance Company without obtaining my authorization. I am aware that my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature _____ Date _____

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ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote a return to work. This form must be completed by a physician.

Name of patient:_____ Date of birth:_____

Address:_____
Street City State Zip

A. DIAGNOSIS / HISTORY

Primary diagnosis:_____ ICD-9 code:_____
Secondary diagnosis:_____ ICD-9 code:_____
Other diagnoses and ICD codes related to this claim:_____

DSM IV Axis I – V (GAF):_____
Symptoms:_____

Is the condition primarily related to: ☐ Employment ☐ Illness ☐ Mental Disorder ☐ Alcohol or Drug Dependence ☐ MVA ☐ Pregnancy ☐ Injury

Date patient became unable to work due to this impairment? Month_____ Day_____ Year_____

Date your patient can return to work: Part time:_____ Full time:_____
OR unable to determine, due to:_____ Follow up in: _____

Patient's Height: _____ Patient's Weight: _____ BP:_____ Patient's Dominant Hand: ☐ Right ☐ Left
Date symptoms first appeared:_____ Date of first visit to you for this condition:_____
Date of most recent visit:_____ Date of next visit:_____
Has your patient ever had the same or similar condition? ☐ No ☐ Yes If yes, indicate when and describe:_____

B. TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.):_____

Treatment complicated by: ☐ Employer / Employee conflict ☐ Significant emotional or behavioral disorder
☐ Alcohol or Drug Dependence ☐ MVA ☐ Other _____

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper):_____

Frequency with which you see your patient: ☐ Weekly ☐ Monthly ☐ PRN ☐ Other:_____
Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? ☐ No ☐ Yes If yes please indicate to whom and dates:

If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? For example, have you had contact with the patient's employer regarding possible job modifications or gradual return to work? ☐ No ☐ Yes If yes please describe the return to work plan:_____

C. HOSPITIALIZATION: (If not hospitalized please proceed to next section.)

If patient was hospitalized, please provide dates: Admitted_____ Discharged_____
Admitting diagnosis:_____ ICD-9 code:_____
Discharge diagnosis:_____ ICD-9 code:_____
Name of hospital:_____ Name of doctor seen at hospital:_____
Address:_____
Street City State Zip Code

D. SURGERY: (If surgery was not performed or is not anticipated to be necessary in the future please proceed to next section.)

Was surgery performed? ☐ No ☐ Yes If yes indicate procedure and date of surgery: _____

Is surgery planned? ☐ No ☐ Yes If yes indicate planned procedure and anticipated date:_____

Name of Patient:_____ Date of Birth_____

E. PREGNANCY: (If patient is not pregnant please proceed to next section.)

If disability is related to pregnancy, please provide the following: LMP_____ First obstetric visit:_____
Expected date of delivery_____ Actual date of delivery_____ Type: ☐ C-Section ☐ Vaginal
Have there been complications resulting in disability prior to delivery? ☐ No ☐ Yes If yes indicate the type of complication:_____

F. ASSESSMENT

Describe your patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
Has your patient reached maximum medical improvement? ☐ No ☐ Yes
If your patient has not reached maximum medical improvement, when do you expect a fundamental or marked change in his/her condition?
☐ Never ☐ Condition expected to regress ☐ Condition expected to improve, State anticipated date_____ ☐ Unable to determine
Is confinement to bed or home medically required? ☐ No ☐ Yes. If yes, please indicate duration of confinement. _____

G. RESTRICTIONS AND LIMITATIONS

If physical or psychiatric limitations exist, how long do you feel that these limitations will last?_____
Has your patient provided a self-report of his/her job tasks? ☐ No ☐ Yes
Based on your knowledge of your patient's job, what reasonable work or job site modifications could the employer make to assist him/her to return to work?

Level of functional impairment:

In a work day, given two breaks and a meal break, your patient can:
Lift (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Carry (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently (how frequently)_____

If allowed positional changes, patient can: (please circle one for each)
Sit: 8 7 6 5 4 3 2 1 0 (hrs)
Stand: 8 7 6 5 4 3 2 1 0 (hrs)
Walk: 8 7 6 5 4 3 2 1 0 (hrs)
Alternately sit/stand : 8 7 6 5 4 3 2 1 0 (hrs)

If the total number of days that the patient can work during a week is limited, please specify the number of days the claimant can work per week. _____

Patient can work with arms in the following positions:
Right arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes
Left arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes

Patient can use arms/hands for repetitive action such as:
Right arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes
Left arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Patient can use his/her head and neck in:
Flexion ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Extension ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Rotation ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Mental Impairment (if applicable)

Please define "stress" as it applies to this claimant: _____
What stress and problems in interpersonal relations has this claimant had on the 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: _____
What obstacles prevent a return to work?_____
If no, would you like assistance in developing a return to work plan? ☐ No ☐ Yes
Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in finding a new job, or in designing a retaining plan which would allow a return to work)? ☐ No ☐ Yes
Comments:_____

PLEASE READ CAREFULLY*************************************

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

Physician's signature:_____ Date:_____

Physicians name (please print):_____ Specialty:_____

Address:_____ City_____ State:_____ Zip code:_____

Phone number:_____ Medical record department fax number:_____

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Signature: _____ Date: _____

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EMPLOYER'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurance provider, we are committed to assisting your employee in a return to productive employment. Please complete the following information thoroughly, as this will allow us to accurately evaluate this claim and assist your employee with a successful return to work. An incomplete claim form will not be accepted.

Employee's name:_____ Social security number: _____

Address:_____
Street City State Zip Code

Telephone number:_____ Date of Birth:_____

EMPLOYEE INFORMATION

Employee's date of hire:_____ Date employee became insured for benefits: _____

What was the employee's permanent job on his or her last day of work? _____

_____

How long had the employee been in this job?_____ Last date employee actually worked:_____

On the last day worked did the employee work a full day? ☐ Yes ☐ No If no, how many hours were worked? _____

Why did your employee stop working? _____

_____

_____

Were there any changes to your employee's job responsibilities prior to the last day of work?

☐ No ☐ Yes If yes, what were the changes and when were they made?_____

_____

What is your employee's regularly scheduled work week? _____Hours per week. _____Hours per day. Hourly wage if applicable:_____

What was your employee's Basic ANNUAL Salary as of his/her last day of work? $_____

Has your employee returned to work? ☐ No ☐ Yes If yes, Part-time date:_____Full-time date:_____

If employee returned to work, he / she returned: ☐ At full capacity ☐ With work restrictions. If the employee returned with restrictions,

please indicate the specific restrictions: _____

_____

SALARY / OTHER INCOME / TAX INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ Short Term Disability benefits ☐ Long Term Disability benefits ☐ Life Insurance Waiver of Premium benefits

If claim is for Life Insurance Waiver of Premium benefits, please indicate:
Effective date of coverage:_____Basic Coverage Amount: $_____
Supplemental Coverage Amount: $_____Total Number of dependents:_____spouse_____children

How many contract days does this employee work:_____ Total number of sick days employee has:_____

If your employee worked based on contracted days, please provide a calendar documenting each contract day.

CONTINUED ON REVERSE SIDE

Name of Employee:_____ **Date of Birth**_____

SALARY / OTHER INCOME / TAX INFORMATION CONTINUED

Has your employee received or will he/she receive any of the following: ☐ Salary continuance ☐ Sabbatical Pay ☐ Sick Leave

If you checked any of the above please complete the following:

The employee used sick leave from _____ to _____ in the amount of $_____ per ☐ Week ☐ Month.

Is the employee's disabling condition work-related? ☐ No ☐ Yes ☐ Unknown

Has a claim been filed with Workers' Compensation? ☐ No ☐ Yes ☐ Unknown

If yes, what is the current status of the Workers' Compensation claim? ☐ Approved ☐ Denied ☐ Currently Disputed
Please send any Worker's Compensation claim information that you may have including benefit payment information if applicable.

If this is an STD claim, does the employee pay any of the STD insurance premium? ☐ No ☐ Yes If yes, the contribution is: ☐ Pre-tax ☐ Post-tax

If "Post-tax", _____% paid by employer _____% paid by employee. $_____employer, $_____employee

If this is an LTD claim, does the employee pay any of the LTD insurance premium? ☐ No ☐ Yes If yes, the contribution is: ☐ Pre-tax ☐ Post-tax

If "Post-tax", _____% paid by employer _____% paid by employee. $_____employer, $_____employee

(Note: If employee paid disability premium is pre-tax, we will deduct FICA tax as if the employer was paying 100% of the disability premium.)

To the best of your knowledge, is your employee receiving, or entitled to receive benefits from any of the following as a result of this disability:

☐ Social Security ☐ Other Government Agency ☐ Teachers or Public Employees' Retirement System
☐ Statutory Disability Income, e.g. Workers' Compensation ☐ Any other Disability or Retirement Plan (Employer-sponsored or not)

FOR ANY YES ANSWER PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name and address of carrier or administrator:_____Telephone Number:_____

RETURN TO WORK CONSIDERATIONS (Complete if employee has not yet returned to work)

Does your company/organization have a return-to-work policy for disabled employees? ☐ No ☐ Yes

Do you, or does someone from your company/organization, maintain contact with your employee? ☐ No ☐ Yes Frequency? _____

Can you provide transitional job duties for your employee to allow a gradual return to work? ☐ No ☐ Yes

Has this information been communicated to your employee's physician? ☐ No ☐ Yes

Have you discussed a return to work with your employee? ☐ No ☐ Yes What is the anticipated return to work date? _____

What is the name, telephone number and title of the supervisor we should contact if we identify a rehabilitation or return-to-work option?

_____
Name Title Telephone Number

Would you like a Vocational Rehabilitation Case Manager to assist your employee in the return to work process? ☐ No ☐ Yes

Do you have any other comments which might help us better manage this claim? _____

_____

CONTACT INFORMATION

Employer's Group Name:_____Group/Policy number: _____

Mailing address:_____
Street City State Zip Code

Name and title of individual completing this form (please print): _____

Telephone number:_____ Fax number: _____

Email address: _____

Signature_____ Date _____

PLEASE ATTACH A JOB DESCRIPTION OUTLINING THE JOB DUTIES AND PHYSICAL DEMANDS OF THIS EMPLOYEE'S OCCUPATION

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ARIZONA WARNING: 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 WARNING: 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 WARNING: 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 damage. 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.

FLORIDA WARNING: 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 guilty of a felony of the third degree.

KENTUCKY WARNING: 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 HAMPSHIRE WARNING: 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 RSA 638:20.

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

NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

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

PENNSYLVANIA WARNING: 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.

WASHINGTON WARNING: 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.

Signature_____ **Date**_____

National Insurance Services
Disability Waiver Service

Dear Administrator:

Any employer who has both Long Term Disability (LTD) insurance and Group Life insurance through National Insurance Services (NIS), has our Disability Waiver Service.

Through our Disability Waiver Service, NIS will initiate the Life Waiver of Premium, (or Life policy conversion, if applicable,) filing process by instructing the LTD insurance company to release medical records to the Life insurance company. Please have your disabled employee complete and mail the form below at the time he/she completes the LTD claim form.

This service:

- SAVES the employee the time and trouble of initiating the medical record transfer process.
- PROMPTS timely application for Life Waiver of Premium which:
    1) Protects the employee's ability to retain all the coverage that he/she is entitled to under the Group Life plan, and;
    2) Saves the employer from spending employee benefit dollars on unnecessary premiums in these days of tight budgets.

(complete, detach below at dotted line, and mail to the address below)

…….

Authorization to Release Disability Information

I hereby authorize **Madison National Life Insurance Company** and/or its agent, to release information, including medical reports, concerning my disability claim to my employer's group Life insurer, **Lafayette Life Insurance Company** to expedite application for Waiver of Life insurance premiums (or a Life Conversion Policy, if applicable.) This authorization is valid for 12 months from the date it is signed. I understand that I may receive a copy of this completed Authorization form, upon request.

Claimant Signature: _____ Date: _____

Claimant Name (print): _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Date of Loss: _____

Mail to: National Insurance Services • 250 South Executive Drive • Brookfield, WI 53005 • (1-800-627-3660)