BOSTON MUTUAL LIFE INSURANCE COMPANY

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

Section I **Employer's Statement** - to be completed by the **employer's** authorized representative.

Section II **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits

Section III **Authorizations to Obtain Information** - to be signed by the **employee**.

Section IV **Attending Physician's Statement -** to be completed by the physician who is treating the **employee.**

Fax completed application to:
Boston Mutual Life Insurance Company
Disability Claim Department
P. O. Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR BML BENEFIT MANAGEMENT SERVICE CENTER.

Fax completed application to:
Boston Mutual Life Insurance Company
Disability Claim Department
P. O. Box 14294
Lexington, KY 40512-4294
Fax Number: 855 864 0530

BOSTON MUTUAL LIFE INSURANCE COMPANY

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

Section I - Employer's Section

To Be Completed by the Employer

Clear Form

This claim is for (Employee's Name)	Social Security Number	Date of Birth

Employee's Address (Street, City, State, Zip)

A. Information About the Employer

Company's Name

Address (Street, City, State, Zip)

Name and Address of Division Where Employee Works (if different from above)

Group Policy Number	Class	Location

B. Information About the Employee

Date employee was hired	Date employee became insured under this plan

What was the employee's regularly scheduled work week?

_____ Hours per Week _____ Scheduled workdays M - F Other: _____

IS EMPLOYEE ENROLLED IN BML'S LONG TERM DISABILITY PLAN ? ☐ Yes ☐ No IF "YES," EFFECTIVE DATE _____

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "Yes, attach copy.

Was the employee insured under your prior STD policy? ☐ Yes ☐ No

If "Yes," please provide the inclusive date of coverage. From _____ Through _____

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No

Did STD & LTD insurance continue while on Family Leave? ☐ Yes ☐ No

Date Leave of Absence started under Family Leave Act: _____

C. Information Needed for Withholding and Reporting Taxes

What percent of this employee's STD benefit is taxable? _____ %.

What percentage, if any, do you contribute towards the cost of the STD premium? _____ %

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____ %.

Is it on a ☐ Pre or ☐ Post-tax basis?

What percent of this employee's LTD benefits is taxable? _____ %

Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____ %

Is it on a ☐ Pre or ☐ Post-tax basis?

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)

Last day employee actually worked:	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _____

Why did employee stop working?

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

Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury or award notice.	Date employee is expected to return to work? _____ Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay: $_____

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

Is employee receiving Salary Continuance or Sick Leave? ☐ Yes ☐ No

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence N/A	Occasionally	Frequently	Continuously
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐

Activity	Description	Frequency	Weight
☐ Pushing	_____	_____	_____ lbs.
☐ Pulling	_____	_____	_____ lbs.
☐ Lifting	_____	_____	_____ lbs.
☐ Carrying	_____	_____	_____ lbs.

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks. _____ _____ %

_____ _____ %

_____ _____ %

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain.

_____

Is it possible to offer the employee assistance in doing the job (e.g., through the use of technology or personal assistance)?
☐ Yes ☐ No If "Yes," explain.

H. Signature

_____ _____

Name (Please print or type) *Title*

_____ _____

Signature *Date*

( ) _____ ( ) _____

Area Code Telephone Number Area Code Fax Number

Fax completed application to:
Boston Mutual Life Insurance Company
Disability Claim Department
P. O. Box 14294
Lexington, KY 40512-4294
Fax Number: 855 864 0530

BOSTON MUTUAL LIFE INSURANCE COMPANY

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

Section II - Employee's Section - To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information About You

Last name	First	Middle Initial	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number

Address (Street, City, State & Zip)

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Personal Cell Telephone Number: ( )

Alternate Telephone Number: ( )

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature | Date | Email Address:

B. For an Injury, answer the following questions

When (i.e., date/time), where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Name of Physician

Date you were first treated by a physician (MM/DD/YYY)

Address of Physician (Street, City, State & Zip)

Telephone Number ( )

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No
If "Yes," explain.

What aspect of your condition made you unable to work?

Are you receiving or eligible for ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other _____
If "Yes," show policy number _____ and name and address of insurer _____

Weekly Amount $_____ Date Payments Start_____ Date Payments Will End _____

Is your condition related to your occupation? ☐ Yes ☐ No If "Yes," explain.

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If "No," explain.

D. Information About the Disability

Last day you worked before the disability

Did you work a full day? ☐ Yes ☐ No If "No," explain.

Your Employer (include division, if applicable)

If you have not returned to work, do you expect to? ☐ Yes ☐ No Date you were first unable to work _____

Since that date, have you done any work? ☐ Yes ☐ No ☐ Part time ☐ Full time
If "Yes, " please indicate dates worked, name of employer and amount earned. _____ _____ _____

Name of employer and amount earned.

E. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $ 20.00 per week). $ _____.__00.__ **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W -4, Employee's Withholding Allowance Certificate, from you. You may go to www .irs.gov to obtain the proper withholding form.

F. Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefit s from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period Boston Mutual Life has approved my disability claim, I must report all details to Boston Mutual Life, immediately. If I receive disability income benefit s greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. Boston Mutual Life has the option to reduce or eliminate future disability payments in order to recover any overp ayment balance that is not reimbursed.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present s false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the p ayment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading fact s or information to an insurance company for the purpose of defrauding or attempting to defraud the comp any. 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application cont aining any false, incomplete, or misleading information is guilty of a felony of the third degree

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For Residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAY-MENT 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.

For residents of 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, commit s 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 stated value of the claim for each such violation.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of 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.

The statements contained in this form are true and complete to the best of myknowledge and belief.

Signature _____ Date _____

Section III - AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Insured's Name (*Please print*) | Date of Birth | Last 4 Digits of Social Security Number

I AUTHORIZE ANY health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes**. I also authorize MIB, Inc. (formerly known as the Medical Information Bureau, Inc.), to provide protected health information.

By my signature below, **I acknowledge that any agreements the person named above has made to restrict protected health information. do not apply to this authorization**, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

I ALSO AUTHORIZE ANY health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration to disclose to BML a complete copy of any and all of the following personal or privileged information, records, or documents relative to the person named above:

Any and all work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to BML at:
Boston Mutual Life Insurance Company, Disability Claim Department, P. O. Box 14294 Lexington, KY 40512-4294.

I UNDERSTAND that once My Information has been disclosed to BML as permitted under this Authorization, it may be re-disclosed by BML as permitted by law or my further authorization. I authorize BML to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures BML may make, unless BML has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to BML. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing BML to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. I acknowledge that I have received a copy of BML's Notice of Information Privacy Practices. A photo copy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian or Personal Representative | Date | Relationship to Insured (if signed by Guardian or Personal Representative)

Consumer Report Authorization

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my claim may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my claim, I will be informed by Boston Mutual of my rights, concerning that action. This authorization will be valid for twelve (12) months, or, if approved, the duration of my claim, whichever is greater.

_____ _____

Claimant Name printed Date

_____

Claimant Signature

Section IV - HISTORY - Attending Physician's Statement

Fax completed application to: Boston Mutual Life Insurance Company, P. O. Box 14294, Lexington, KY 40512-4294 Fax: (855) 864 0530

Patient's Name:	Last 4 digits of Social Security Number:	Date of Birth:

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy ☐ Mental/Nervous Condition

Is condition due to an illness or an injury that is work related? ☐ Yes ☐ No | Height | Weight

If pregnancy, what is the expected date of delivery? Month_____ Day_____ Year_____ LMP Date_____

DIAGNOSIS

Diagnosis: (including any complications) | CD9 Codes _____ _____

Subjective Symptoms

Physical Findings: (list all test results, or enclose test)

Test:_____ Date:_____ Results: _____

Test:_____ Date:_____ Results: _____

Blood Pressure: (Systolic) _____ (Diastolic) _____ (Date) _____

Remarks:

TREATMENT

Date of onset of this condition? | List all dates of treatment for this condition since patient ceased work: _____ _____ _____ | Date of next office visit:

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) _____ _____

Name:	Address:	Specialty:

Nature of treatment for this condition : (including surgery/medications)

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted: _____ _____

Name of Hospital(s):_____ Date(s) discharged : _____ _____

Address:_____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date:_____ Procedure: _____ CPT Code:_____

Progress: (please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity
Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment (if applicable)?

☐ Inadequate information to make assessment.

☐ Essentially good functioning in all areas. Occupationally and socially effective.

☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.

☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.

☐ Major impairment in several areas--work, family relations. Avoidant behavior, neglects family, is unable to work.

☐ Inability to function in almost all areas.

Date patient ceased work due to this impairment: _____

If physical or psychiatric limitations exist, indicate the date limitations lasted, or will last through: _____

Attending Physician's Name:	Telephone Number: ( )	Fax Number: ( )

Address: (Street, City, State & Zip Code)

Social Security Number or E.I.N. Number:	Degree:	Specialty:

Signature:	Date Signed: