

BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492



FAMILY MATTERS. NO MATTER WHAT.

DISABILITY INCOME AND/OR WAIVER OF PREMIUM CLAIM KIT

INSTRUCTIONS FOR FILING A DISABILITY INCOME AND/OR WAIVER OF PREMIUM CLAIM

You may be eligible for benefits following a waiting period. If you anticipate that your disability will extend beyond the waiting period, please submit your claim now.

Be sure to continue to pay premiums until a decision is made on your claim.

1. Please complete **all sections** of the claim form.
 - Policyholder’s statement of claim
 - Description of occupation
 - Educational/Work Experience

2. Please complete the **top section** of the Attending Physician’s Statement. (**Name, Social Security Number and Policy Number**)

Please give the Attending Physician’s Statement to your doctor to complete.

Your attending physician should fully complete both pages of the Attending Physician’s Statement. A physician who can certify your total disability should complete this section.

3. Please complete the HIPAA authorization form.

4. Please read the “Fraud Warning Notice” for your state.

Please be sure to fully complete all forms to prevent unnecessary delays in processing your claim.

**If you should need assistance in the completion of the claim form
Please call (877) 212-2950
Mail forms to: Boston Mutual Life Insurance Company – 120 Royall Street • Canton, MA 02021**

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POLICYHOLDER'S STATEMENT OF CLAIM

(If you need more space, please use the back of this form)

Insured's Name *(all known names)* _____

Social Security No. _____ Date of Birth _____ Telephone No. _____

Home Address _____
Street City or Town State Zip Code

Policy Number(s) _____

Last day worked _____ When did your disability start? _____ When do you expect to return to work? _____

Nature of Illness or Injury _____

If Accident - Date and Time _____ Place _____

Did Accident occur at work? _____ When did you first know you had this condition? _____

How did injury occur? _____

If pregnant, provide due date: _____

If hospitalized, give name and address of hospital(s) _____

Dates confined to hospital(s) _____

Name of family physician, address and telephone number _____

Name of other physician(s), addresses and telephone numbers _____

Gross monthly income before disability \$ _____ Current Monthly Income \$ _____

	Applied	Date	Denied	Appealing	Company/Agency - Claim No.
Worker's Compensation	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Social Security	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other Disability Benefits <i>(Group, LDT, etc.)</i>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
State Disability	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Retirement or Pension Plan	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Private Insurance Plan	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, consumer reporting agency, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Boston Mutual Life Insurance Company, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Boston Mutual Life Insurance Company to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Boston Mutual Life Insurance Company to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Boston Mutual Life Insurance Company to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Boston Mutual Life Insurance Company Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.

X _____
Signature Date

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DESCRIPTION OF OCCUPATION

Insured's Name: _____ Policy No. _____

Please fully describe the occupational duties that you were performing immediately prior to your disability.

Employer: _____ Telephone No: () _____ Date of Hire _____

Employer's Address: _____

Normal hours worked each week: From _____ To _____ Your job title: _____

How many years have you worked in this occupation? _____ How long have you performed the duties listed below? _____

Your monthly earned income immediately preceding your disability: _____

Do you have any other part time jobs? YES NO If yes, please explain. _____

DAILY OCCUPATIONAL DUTIES

List and describe the most important duties first	Hours per week
1.	
2.	
3.	
4.	
5.	

INSTRUMENTS AND EQUIPMENT USED

List those used most frequently first	Hours per week
1.	
2.	
3.	
4.	
5.	

Where do you work? Mostly indoors Mostly outdoors Equally in and out

If there is any additional information about your job that you believe will help us to understand the occupational duties you were performing, please explain (*use back of this form if necessary*).

PHYSICAL REQUIREMENTS OF YOUR OCCUPATION

	Occasionally	Frequently	Constantly	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maximum weight you lift or carry:	10 lbs <input type="checkbox"/>	20 lbs <input type="checkbox"/>	50 lbs <input type="checkbox"/>	100 lbs <input type="checkbox"/>
Maximum weight you most frequently lift or carry:	10 lbs <input type="checkbox"/>	20 lbs <input type="checkbox"/>	50 lbs <input type="checkbox"/>	100 lbs <input type="checkbox"/>

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EDUCATION / WORK EXPERIENCE

Insured's Name: _____ Policy No: _____

Please complete this form to the best of your ability. Use an additional sheet of paper if you need more space.

EDUCATIONAL BACKGROUND

Highest grade completed: _____

Did you attend college or other school of higher learning? YES NO

If yes, name of institution: _____

Degree(s) or Certificate(s): _____

Major field(s) of study: _____

WORK EXPERIENCE

List chronologically the jobs you have had as an adult and indicate:

1. Type of work. Be specific: *i.e. sales, accountant, clerk, laborer, etc.*
2. Physical Requirements: *i.e. heavy lifting, standing, sitting, etc.*
3. Supervisory Experience

Dates	Type of Work	Physical Requirements	Supervisory Experience	
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>

Additional courses taken, special skills, or hobbies. Please be specific, such as carpentry, auto repair, etc.

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ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY INSURED

Insured: _____ Social Security No: _____ Policy No: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

HISTORY	Patient's symptoms result from <i>(check all that apply)</i> <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy (Due Date: _____) <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident Date Symptoms first appeared or date of accident/injury: _____ Date total disability commenced: _____ Date patient first consulted you for this condition: _____ Date of most recent visit: _____ Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Other <i>(please specify)</i> _____ Has patient had same or similar condition: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Please explain: _____ Name(s) and addresses of other treating or referring physician(s) _____ _____ Hospital name: _____ Confinement Dates: _____ thru _____
	DIAGNOSIS Diagnosis <i>(including any complications or secondary diagnoses)</i> _____ Subjective Symptoms: _____ Objective finding <i>(include results/copies of x-rays, lab tests, EKGs, MRIs and scans)</i> _____
	TREATMENT & PROGRESS Please describe present treatment plan: <i>(including surgery, physical therapy or psychotherapy)</i> _____ Please advise all medications prescribed: _____ IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING HER/HIS OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING ANY OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO When was or will patient be able to resume ANY PART of her/his work? _____ When was or will patient be able to resume ALL of her/his work? _____ Please describe any temporary restrictions and/or any return to work plan: _____ _____
	CARDIAC (Complete only if applicable) Functional Capacity: <input type="checkbox"/> Class 1 <i>(no limitation)</i> <input type="checkbox"/> Class 2 <i>(slight limitation)</i> <input type="checkbox"/> Class 3 <i>(marked limitation)</i> <input type="checkbox"/> Class 4 <i>(complete limitation)</i> Blood Pressure <i>(latest reading)</i> _____ as of <i>(date)</i> _____ Is patient in a cardiac rehabilitation program? <input type="checkbox"/> YES <input type="checkbox"/> NO



CONTINUATION OF ATTENDING PHYSICIAN'S STATEMENT

Insured: _____ Social Security No: _____ Policy No: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

PHYSICAL IMPAIRMENT	<p>(Complete only if applicable)</p> <p><input type="checkbox"/> CLASS 1 - No limitation of functional capacity; capable of heavy work. No restrictions. 0 -10%</p> <p><input type="checkbox"/> CLASS 2 - Medium manual activity. 15 -30%</p> <p><input type="checkbox"/> CLASS 3 - Slight limitation of functional capacity; capable of light work. 35 -55%</p> <p><input type="checkbox"/> CLASS 4 - Moderate limitation of functional capacity; capable of clerical/administrative (<i>sedentary</i>) activity. 60 -70%</p> <p><input type="checkbox"/> CLASS 5 - Severe limitation of functional capacity; incapable of minimal (<i>sedentary</i>) activity. 75 -100%</p> <p>Remarks: _____</p>
PSYCHIATRIC IMPAIRMENT	<p>(Complete only if applicable)</p> <p>a) Please define "stress" as it applies to this claimant. _____</p> <p>b) What stress and problems in interpersonal relations has claimant had on job? _____</p> <p><input type="checkbox"/> CLASS 1 - No limitation of functional capacity; capable of heavy work. No restrictions. 0 -10%</p> <p><input type="checkbox"/> CLASS 2 - Medium manual activity. 15 -30%</p> <p><input type="checkbox"/> CLASS 3 - Slight limitation of functional capacity; capable of light work. 35 -55%</p> <p><input type="checkbox"/> CLASS 4 - Moderate limitation of functional capacity; capable of clerical/administrative (<i>sedentary</i>) activity. 60 -70%</p> <p><input type="checkbox"/> CLASS 5 - Severe limitation of functional capacity; incapable of minimal (<i>sedentary</i>) activity. 75 -100%</p> <p>Remarks: _____</p>
PROGNOSIS	<p>Prognosis: <input type="checkbox"/> Terminal <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excellent</p> <p>Has patient reached maximum medical improvement? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>When could trial of employment commence: Part-Time _____ Full-Time _____</p>
REHABILITATION	<p>Is patient a suitable candidate for rehabilitation services? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Please Explain: _____</p> <p>Would job modification enable patient to work with impairment? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Please Explain: _____</p> <p>Would vocational counseling and/or retraining be recommended? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Please Explain: _____</p>
<p>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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.</p>	
<p>X _____ Date _____</p> <p>Signature _____ Date _____</p> <p>Physician's Name: _____ Degree or Specialty: _____</p> <p>Address: _____ Street _____ City or Town _____ State _____ Zip Code _____</p> <p>Telephone Number: () _____ Fax Number: () _____</p> <p>Signature: _____ Date: _____</p>	

FRAUD WARNING NOTICES – For Use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

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.

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 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.

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.

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 guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any 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.

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.

LOUISIANA: 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.

MAINE: 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 or a denial of insurance benefits.

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.

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 Rev. Stat. Ann. §638:20.

see other side

FRAUD WARNING NOTICES – For Use with Claim Forms (cont.)
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

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.

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 stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing 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: WARNING: 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 any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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 are 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.

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.

VIRGINIA: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

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 an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: 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.