

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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Social Security Disability or Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes	Unemployment Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes
Vacation/Bonus Pay	<input type="checkbox"/> No <input type="checkbox"/> Yes	Retirement Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other Income Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes
Automobile No-Fault	<input type="checkbox"/> No <input type="checkbox"/> Yes	Short Term Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	Workers' Compensation	<input type="checkbox"/> No <input type="checkbox"/> 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

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

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 _____

Madison National Life

Insurance Company, Inc.

P.O. BOX 5008, MADISON, WI 53705

Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

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. HOSPITALIZATION: (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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