



**Phone Number:** 1 (800) 782-8533  
**Fax:** 1 (216) 898-0685

**Return to Fort Dearborn Life at:**  
Attention Claims Department  
20445 Emerald Parkway, Suite 400  
Cleveland, Ohio 44135

**NOTE:** All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

## NOTICE OF CLAIM — Employer's Instructions

Approximately 6 to 8 weeks before the end of the elimination period:

- A. Complete the Employer's Report of Claim in full;
- B. Give claim form to claimant for completion; and
- C. Request copy of awards from other sources of benefits: Social Security, Workers' Comp., retirement, state disability, and others.

When claimant returns the form to you:

- A. Attach:
  - Job description (detailed duties)
  - Copy of enrollment card (only for contributory coverage, if available)
  - Documentation of earnings if other than straight salary
  - If Workers' Comp. claim filed, include copy of First Report of Accident and the decision
- B. Return, together with all attachments, to Fort Dearborn Life at the address shown above.

## APPLICATION FOR LTD BENEFITS — Employee's Instructions

- A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Fort Dearborn Life or its representative to secure additional information if necessary to make a decision on your claim.
- B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

- A. Attach:
  - A copy of your birth certificate (only if disability is indefinite and you are over age 50)
  - A copy of Social Security and other income entitlement awards; and
- B. Return to your employer.

## ATTENDING PHYSICIAN'S STATEMENT (APS) — Physician's Instructions

As soon as the claimant gives you this form:

- A. Complete the APS on the back of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.
- B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

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. (Not enforceable in Oregon or Virginia.)



<b>C L A I M A N T</b>	1. Employee's Name (Last, First, Middle Init.)		2. Social Security No.	3. Date of Birth
	4. Address		City	State Zip Code
<b>E M P L O Y M E N T</b>	5. Insurance Class	6. Employee Date of Hire	7. Date employee became insured for LTD	8. Date employee was actually last present at work
	9. Occupation at time last worked (attach job description)		10. Work schedule at time last worked No. of days per week _____ No. of hours per day _____	
	11. Reason for stopping: <input type="checkbox"/> Sickness <input type="checkbox"/> Granted LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Other <input type="checkbox"/> Resigned <input type="checkbox"/> Vacation		12. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time Date _____ Date _____	
<b>I N C O M E</b>	13. How is employee paid? <input type="checkbox"/> Straight Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Salary & Commissions <input type="checkbox"/> Commissions Only <input type="checkbox"/> Salary & Bonus		14. Employee's Basic <u>Monthly</u> Earnings \$ _____ LTD Benefit _____ (If salary is based on less than 12 mos. - No. of mos. _____ )	
	15. Employee's % of LTD premium contribution: _____		Employee pays _____ Employer pays _____	
<b>O T H E R B E N E F I T S</b>	16. Has insured received other disability payments since time last worked? Salary Continuance: _____ Insured Short Term Disability _____ Other type: _____ <input type="checkbox"/> Yes Wkly. Amt. _____ <input type="checkbox"/> Yes Wkly. Amt. _____ <input type="checkbox"/> Yes Wkly. Amt. _____ Date benefits cease _____ Date benefits cease _____ Date benefits cease _____ <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No			
	17. Did claim result from job activity? <input type="checkbox"/> Yes (Explain) <input type="checkbox"/> No	18. Has Workers' Compensation claim been filed? <input type="checkbox"/> Yes (Enclose copy of 1st report of accident) <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Denied (Enclose copy of denial)		19. Workers' Comp. Weekly Amount: \$ _____
<b>R E T I R E M E N T</b>	20. Is employee covered by employer sponsored retirement plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Does retirement plan contain a disability provision? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	22. Is employee or will this employee be eligible for a disability or retirement pension? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" type: <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____		Monthly Amount \$ _____ Commence Date of Benefits: _____ (enclose copy of summary plan description)	
NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.				
<b>C E R T I F I C A T I O N</b>	23. Employer's Name (state association and name of policyholder, if other)		24. Telephone No. ( )	25. Group Policy No.
	26. Address			
	27. Employer (Taxpayer) I.D. Number (EIN) _____ - _____ OR		29. Name of person completing this form (please type or print)	
	28. Public Employer Social Security No. 69 _____ - _____		29. Name of person completing this form (please type or print)	
30. Signature of Authorized Insurance Representative		Title		Date



<b>C L A I M A N T</b>	1. Full Name (Last, First, Middle Init.)		2. Maiden Name		3. Alias Name		4. Social Security No.		5. Phone Number ( )			
	6. Address				City			State		Zip Code		
	7. Date of Birth Mo. Day Year		8. Height ft. in.		9. Weight		10. Sex <input type="checkbox"/> M <input type="checkbox"/> F		11. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Spouse's date of birth Mo. Day Year First Name	
											13. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Number of children (Under age 19)				15. List names and dates of birth of unmarried children who have not finished high school.								
<b>E M P L O Y M E N T</b>	16. Employer's Name						17. Group Policy No.					
	18. Occupation (List the duties of your occupation at the time of disability)											
	19. Date of accident or date first noticed symptoms of illness: Mo. Day Year			20. I have been unable to work because of the disability since: Mo. Day Year			21. I returned to work on a part time basis on: Mo. Day Year			22. I returned to work on a full time basis on: Mo. Day Year		
	23. Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No				24. If "yes," explain Have you or do you intend to file a Workers' Comp. Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>C L A I M H I S T O R Y</b>	25. Describe how and where accident occurred or describe the onset and nature of your illness.											
	26. Date you were first treated for your illness or injury. Mo. Day Year			27. Treated by: Hospital: _____ Name _____ Street Address _____ City _____ State _____ Zip Code _____ Doctor: _____ Name _____ Street Address _____ City _____ State _____ Zip Code _____								
	28. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete No. 27.			29. Treated by: Hospital: _____ Name _____ Street Address _____ City _____ State _____ Zip Code _____ Doctor: _____ Name _____ Street Address _____ City _____ State _____ Zip Code _____								
	30. Describe other income you are receiving:											
<b>O T H E R I N C O M E</b>	Yes		No		Type		Date Amount		Date Began		Term.	
	<input type="checkbox"/>		<input type="checkbox"/>		Social Security (disability or retirement)		\$ _____		_____		_____	
	<input type="checkbox"/>		<input type="checkbox"/>		State disability		\$ _____		_____		_____	
	<input type="checkbox"/>		<input type="checkbox"/>		Retirement (normal, early or disability)		\$ _____		_____		_____	
<input type="checkbox"/>		<input type="checkbox"/>		Workers' Compensation		\$ _____		_____		_____		
<input type="checkbox"/>		<input type="checkbox"/>		Group disability benefits		\$ _____		_____		_____		
<input type="checkbox"/>		<input type="checkbox"/>		Other (describe) _____		\$ _____		_____		_____		
31. Have you applied, or do you plan to apply for benefits described above? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Type _____		Date application filed _____										
Type _____		Date application filed _____										
32. If your request for benefits is approved, do you want us to withhold amounts from each benefit for Federal Income Tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete and attach IRS Form W4S.												
<p><b>AUTHORIZATION:</b> I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Fort Dearborn Life Insurance Company's (FDL) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim.</p> <p>This authorization expires on the date I receive notice of FDL's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation. Information disclosed may be redisclosed and no longer protected by federal privacy laws. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from FDL. <b>If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny my claim.</b></p>												
Signature of Employee _____						Date _____						



Name of patient		Date of Birth	* Please submit bill for records with this claim.	
HISTORY	(a) When did symptoms first appear or accident happen?	(b) Date patient ceased work because of disability?	(c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes If "Yes" state when and describe <input type="checkbox"/> No	
	(d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(e) Names and addresses of other treating physicians		
DIAGNOSIS	(a) Diagnosis (Including complications) Please submit all office notes in regard to this condition*		(b) Subjective symptoms	
	(c) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings?)			
TREATMENT	(a) Date of first visit	(b) Date of last visit	(c) Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)	
	(d) Nature of treatment (Including surgery and medications prescribed, if any)			
PROGRESS	(a) Has patient <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?	(b) Is patient <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?		
	(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from _____ through _____ If, yes, give Name and Address of Hospital:			
CARDIAC	(a) Functional capacity (American Heart Ass'n.) <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation)		(b) Blood Pressure (last visit) _____ systolic/diastolic	
	(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles). <input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity* (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%) Remarks:			
IMPAIRMENT	(b) Mental Impairments (If applicable)			
	(a) Please define "stress" as it applies to this claimant. (b) What stress and problems in interpersonal relations has claimant had on job? <input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks:			
PROGNOSIS	(a) Is patient now totally disabled? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Date patient became disabled due to present illness	
	(c) When do you expect a fundamental or marked change in the future? <input type="checkbox"/> 1 Mo. <input type="checkbox"/> 1-3 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> Never. Applies To: <input type="checkbox"/> Patient's job <input type="checkbox"/> Other Work			
REHAB	(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Can present job be modified to allow for handling with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	(c) When could trial employment commence? Date _____ PATIENT'S JOB <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date _____ ANY OTHER WORK <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time			
REMARKS	(Limitations, Therapy, etc.)			
Name (Attending Physician) <i>Print</i>		Degree	Telephone ( ) Fax #: ( )	
Street Address		City or Town	State	Zip Code
Signature			Date	



**The laws of some states require us to furnish you with the following notice:**

**Arkansas & Massachusetts**

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.

**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.

**District of Columbia**

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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kansas**

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 information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

**New Jersey**

Any person who knowingly files false or misleading information on an application for insurance coverage 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.

**Oklahoma**

Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

**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.

**Washington**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

**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. (Not enforceable in Oregon or Virginia.)