

Instructions

Cardif Life Insurance Company

P.O. Box 77-0250 • Miami, FL 33177-0250
Phone: 1-877-522-7343 • Fax: 305-234-1747

YOU, YOUR TREATING PHYSICIAN AND YOUR EMPLOYER MUST COMPLETE A PORTION OF THIS CLAIM PACKET.

IF YOU HAVE MORE THAN ONE POLICY WITH OUR COMPANY, PLEASE SUBMIT ONE SET OF CLAIM FORMS INDICATING THE DIFFERENT LOAN ACCOUNT NUMBERS.

FAILURE TO COMPLETE THE REQUIRED SECTIONS AND PROVIDE THE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.

PLEASE SUBMIT ONLY ORIGINAL CLAIM FORMS TO THE ADDRESS LISTED ABOVE.

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

If the required sections are not complete or if the attachments are not included, the processing of the claim will be delayed. (Check box after each item is completed)

- 1. You, the Claimant, must complete, sign and date the Notice Of Disability Claim form. If you are receiving Social Security Disability, provide a copy of your award letter.
- 2. You, the Claimant, must complete, sign and date the Authorization To Obtain And Disclose Information.
- 3. Have your treating physician complete, sign and date the Attending Physician's Statement.
- 4. Have your employer complete, sign and date the Statement of Employer. If you are self-employed, please complete the form yourself and provide us with a copy of your most recent business tax forms.

PRIVACY POLICY

Cardif Life Insurance Company Respects Your Privacy

Protecting the personal information of the individuals we serve is a priority for Cardif Life Insurance Company. We collect, retain and use personal information about individuals only for the purpose of serving their insurance needs and providing service to them.

This notice describes how we handle personal information of the individuals we serve. It is only for your information; no action on your part is needed.

What kind of information is collected and disclosed?

The type of information we may collect about you includes:

- Information you provide on applications or other forms, or in your verbal responses to our questions. This may include identifying information such as names, addresses, and telephone numbers. It also may include answers to health related questions we may ask you.
- Information about your transactions with us including policies purchased and premium payment history.
- Information we receive about you from other sources, such as your employer, doctors, hospitals, pharmacies, health insurance carriers, and other third parties.

You may have the right to access and correct personal information collected. Upon your request, we will provide you with more detailed information regarding the collection, use and disclosure of personal information, and your rights to access and correct the information. If you want to request more detailed information, contact us,

- We do not sell customer lists or any personal information regarding our customers.
- We do not disclose nonpublic personal information about customers or former customers to third parties, except as required to provide needed services to you and permitted by law.

How do we safeguard your privacy?

- We maintain physical, electronic and procedural safeguards to protect your personal information.
- We restrict access to nonpublic personal data to those employees who need to know that information in order to provide products or services to you.
- We communicate to employees, in writing, the importance of protecting confidential information. We may amend our privacy policies at any time.

If you have questions regarding this notice, please contact us at the address or phone number below.

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Notice of Disability Claim

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**Do not submit this form alone. This form must be accompanied by the
Attending Physician's Statement and the Statement of Employer when submitting to the Company.**

For Claimant to Complete (Please print clearly and fill **ALL** blank spaces. Illegible words or blank spaces will delay the processing of your claim.)

A. Name _____ Soc. Sec. No. <input type="text"/> - <input type="text"/> - <input type="text"/> Street Address _____ City _____ State _____ Zip _____ Telephone Number () _____ Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/>	
B. Name and Address of Lending Institution (where you send your payment) _____ _____ Lending Institution Telephone Number () _____	C. Date of Loan <input type="text"/> - <input type="text"/> - <input type="text"/> Loan Account Number _____ Certificate No. _____
D. Employer on Effective Date of Loan Name _____ Address _____ Telephone Number () _____	E. Current Employer (If Different from Employer in Number 4) Name _____ Address _____ Telephone Number () _____
F. Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide a copy of your most recent business tax form. Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide date <input type="text"/> - <input type="text"/> - <input type="text"/> Reason _____	
G. Describe your disability. (If injury was due to an auto accident, provide a copy of the motor vehicle accident report.) _____ _____ Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain _____ Is your disability caused by an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain _____ Date symptoms first appeared <input type="text"/> - <input type="text"/> - <input type="text"/> Date you were first treated by a physician <input type="text"/> - <input type="text"/> - <input type="text"/> Date you became totally disabled <input type="text"/> - <input type="text"/> - <input type="text"/>	
H. Provide complete names and addresses of all treating physicians, including family physician, hospitals and pharmacies within the past five (5) years Name _____ Street _____ City _____ State _____ Zip _____ Physician: _____ Physician: _____ Physician: _____ Hospital: _____ Hospital: _____ Pharmacy: _____ Pharmacy: _____ <i>*Attach a separate sheet if more space is needed.</i>	Reason/Diagnosis: _____ _____ _____ _____ _____ _____
I. Provide complete name, address, telephone number, group and member number of your group health insurance carrier(s). _____ _____	
J. Are you now receiving or have you ever received a disability pension or compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide date <input type="text"/> - <input type="text"/> - <input type="text"/> Are you receiving Social Security Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide award date <input type="text"/> - <input type="text"/> - <input type="text"/> ATTACH A COPY OF YOUR AWARD LETTER. Have you filed for Unemployment Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If receiving, provide date benefits began <input type="text"/> - <input type="text"/> - <input type="text"/>	

X

Signature of Claimant

Date

Attending Physician's Statement

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IF DIAGNOSIS IS RELATED TO MENTAL OR PSYCHIATRIC ILLNESS, PLEASE FILL OUT THE BACK PORTION OF THIS FORM.

Patient Name (Please Print)	Height	Weight	Date of Birth □□ - □□ - □□□□	Social Security Number □□□□ - □□ - □□□□	
History	A. When did symptoms first appear or accident happen? ____/____/____	B. Date of 1st consultation for this condition ____/____/____	C. Date you advised your patient to stop working ____/____/____	D. Has patient ever had same or similar condition? If Yes, when? <input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____	
	E. Is condition due to or exacerbated by an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		F. Name and address of referring physician (If any)		
Diagnosis	A. Diagnosis (Including any Complications)	Include ICD 9 code	B. Is Condition Due to Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated Date of Delivery: ____/____/____		
	A. Date of last visit ____/____/____	B. Date of next visit ____/____/____	C. Frequency of visits		
Treatment	D. Has patient had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ____/____/____ Type of surgery performed:				
	E. Describe current and future treatment plan (including surgery and medications prescribed, if any.) Provide all applicable dates.				
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"/> Bed Confined <input type="checkbox"/> House Confined <input type="checkbox"/> Hospital Confined		
	C. When will patient: Return to Patient's Occupation <input type="checkbox"/> 1-3 mos. <input type="checkbox"/> 3-6 mos. <input type="checkbox"/> 6-12 mos. <input type="checkbox"/> more than 12 <input type="checkbox"/> Never Return to Any Occupation <input type="checkbox"/> 1-3 mos. <input type="checkbox"/> 3-6 mos. <input type="checkbox"/> 6-12 mos. <input type="checkbox"/> more than 12 <input type="checkbox"/> Never				
	D. Has patient been admitted to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, confined from ____/____/____ to ____/____/____	E. Name and address of hospital			
Classification	Cardiac (If Applicable) A. Physical Impairment (*As defined in federal dictionary of occupational titles) <input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work.* No restrictions. <input type="checkbox"/> Class 2 - Medium manual activity.* <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work.* <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity.			B. Blood pressure last visit _____ Systolic/Diastolic	
	C. In your expert opinion, how would you qualify this patient? <input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Non-Disabled				
Prognosis	A. Does patient currently have Limitations/restrictions from: Patient's Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No Any Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No	B. Describe specific limitations and/or restrictions			
	C. If the limitations and/or restrictions can be accommodated, would you release patient to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Part time <input type="checkbox"/> Full time If No, explain:			D. Date employment could begin ____/____/____	
Name of Attending Physician - PLEASE PRINT			Degree & Specialty		
Street Address			City	State	
			Zip		
X Signature of Attending Physician (The above statements are true and complete to the best of my knowledge.)			Date		
			Are you, the physician, related to this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what is the relationship?		
			Telephone Number □□□□ - □□□□ - □□□□		
			Fax Number □□□□ - □□□□ - □□□□		

Behavioral Health Statement

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Patient Name (Please Print)		Date of Birth □□ - □□ - □□□□	Social Security Number □□□□ - □□ - □□□□
A. Have you advised your patient to stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what date ___/___/___ If Yes, please provide your rationale for recommending disability leave. _____		B. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ___/___/___	
C. Diagnostic Impressions: Axis I: _____ Axis II: _____ Axis III: _____		Axis IV: _____ Axis V: Global Assessment of Functioning; Current _____ Prior to Work Leave: _____	
D. What was the patient's emotional state during the exam? (Describe affect type, range, intensity and congruence with content discussed) Panic Attacks <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify below: • Frequency of panic attacks: _____ • Duration of panic attacks: _____			
E. Behaviors observed during exam: _____ Psychomotor activity and ability to apply effort: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Impaired; Describe: _____ Presented with appropriate dress and hygiene in session? <input type="checkbox"/> Yes <input type="checkbox"/> No; Describe: _____ Impulse Control (e.g. substance abuse, manic behavior, aggressive behavior): _____ Speech: <input type="checkbox"/> Slurred <input type="checkbox"/> Pressured <input type="checkbox"/> Stammering <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Over Productive <input type="checkbox"/> Under Productive			
F. Risk to self/others: Suicidal Ideations <input type="checkbox"/> Yes <input type="checkbox"/> No Homicidal Ideations <input type="checkbox"/> Yes <input type="checkbox"/> No Plan reported; if yes, please describe _____ Able to report reasons for not harming self/others? <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain _____			
G. Date initiated care: ___/___/___ Inpatient Care: Date(s) of Hospitalization ___/___/___ Intensive Outpatient (IOP) ___/___/___ to ___/___/___ Days per week _____ Hours per day _____ Outpatient Psychotherapy: Frequency: _____ Date of next scheduled visit: ___/___/___ Medication Management: Frequency: _____ Date of next scheduled visit: ___/___/___ Current Medications/changes in medication: _____ _____		H. Currently, patient is: <input type="checkbox"/> Released to work full duty as of ___/___/___ <input type="checkbox"/> Released to return with restrictions as of ___/___/___ Please list restrictions: <input type="checkbox"/> Unable to work at this time. Give exact dates of disability: ___/___/___ to ___/___/___	
I. Medication side effects: <input type="checkbox"/> Yes <input type="checkbox"/> No; Describe side effects _____			
Name of Attending Physician (PLEASE PRINT)		Degree & Specialty	Telephone
X Signature of Attending Physician (The above statements are true and complete to the best of my knowledge.)		Date	

Statement of Employer

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IF YOU ARE SELF-EMPLOYED PLEASE PROVIDE A COPY OF YOUR BUSINESS INCOME TAX FORMS.

EMPLOYER MUST COMPLETE THIS FORM (PLEASE PRINT)		Check this box if self-employed <input type="checkbox"/>
A. Employer's Name and Address 		B. Employee's Date of Birth Employee's Social Security Number <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;"> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div style="border: 1px solid black; padding: 2px;"> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> </div>
C. Employee's Name and Address 		D. Employment Classification <input type="checkbox"/> Full Time <input type="checkbox"/> Other: Explain _____ <input type="checkbox"/> Part Time
E. Date of Hire Occupation on date last worked 		
F. Brief description of job activities on date last worked 		G. Employee's work schedule Check off regular workdays <input type="checkbox"/> SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT _____ Days per week _____ Hours per day
(We may require a copy of employee's job description and/or attendance history.)		
H. Date last worked 	I. Current employment status: <input type="checkbox"/> Medical Leave <input type="checkbox"/> Other Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired <input type="checkbox"/> Other: Explain _____	J. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide date ____/____/____ <input type="checkbox"/> Full Time <input type="checkbox"/> Regular Position <input type="checkbox"/> Part Time <input type="checkbox"/> Other Position
K. Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, check the appropriate box: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 30%;"> <input type="checkbox"/> Layoff ___ Seasonal ___ Non Seasonal <input type="checkbox"/> Terminated </div> <div style="width: 30%;"> <input type="checkbox"/> Strike <input type="checkbox"/> Retired <input type="checkbox"/> Disability Leave <input type="checkbox"/> Normal Shutdown </div> <div style="width: 30%;"> <input type="checkbox"/> Voluntary Termination <input type="checkbox"/> Military Leave <input type="checkbox"/> Willful/Criminal Misconduct </div> <div style="width: 30%;"> <input type="checkbox"/> Other: Explain _____ </div> </div>		
L. Are you able to accommodate the medical restrictions and/or limitations? (i.e., job modification, part time, etc.) Explain _____ 		
M. Is employee eligible for: <div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> Group Benefits Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> <div style="width: 20%;"> Workers' Compensation Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> <div style="width: 60%;"> Name of Group Carrier, Address and Telephone Number </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> Has Workers' Compensation claim been filed? Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> <div style="width: 60%;"> Name of Workers' Compensation Carrier, Address and Telephone Number </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> If Workers' Compensation claim has been denied, please submit a copy of the denial with this claim. </div> <div style="width: 20%;"> Group Policy No. </div> <div style="width: 20%;"> Workers' Compensation ID No. </div> </div>		
N. Employer's Taxpayer ID Number (EIN) or Public Employer Social Security Number. If you have neither, explain. 		
Telephone Number <div style="border: 1px solid black; padding: 2px;"> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>	Extension <div style="border: 1px solid black; padding: 2px;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>	Fax Number <div style="border: 1px solid black; padding: 2px;"> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>

X

Name/Title of Authorized Representative (Please Print)	Signature of Authorized Representative	Date
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(The above statements are true and complete to the best of my knowledge.)