

# **VB Disability Claim Form** **Employee Statement**



ManhattanLife™

Employee's Name \_\_\_\_\_ Policy No. \_\_\_\_\_  
(If this is a name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.)

Date of Birth \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone No. \_\_\_\_\_

Is this a new address?  Yes  No

**Primary Care Physician's Name** \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Physical Work Location (City and State): \_\_\_\_\_ Years at Location: \_\_\_\_\_

List the job duties/responsibilities of your occupation at the time of the disability **(and submit a job description)**:  
\_\_\_\_\_  
\_\_\_\_\_

Is the disability related to:

Pregnancy      Yes      No **(If Yes** and prior to delivery, please submit medical records and flow charts)

Accident      Yes      No **(If Yes** and the accident was related to a Motor Vehicle Accident, please submit police report)

Illness/Non-Routine Care      Yes      No

Date of the first symptoms of the illness or date of accident \_\_\_\_\_

Date you were first treated \_\_\_\_\_

First date you were unable to work as a result of your disability \_\_\_\_\_

Did your injury or illness occur at work or as a result of your job?      Yes      No

If yes, did you inform your employer?      Yes      No

### **Reported To:**

Employer Representative Name \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

If work related, please explain \_\_\_\_\_

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim?      Yes      No

Describe the onset and nature of your illness or describe how and where the accident occurred:  
\_\_\_\_\_  
\_\_\_\_\_

What aspect of your condition made you unable to perform your job: \_\_\_\_\_  
\_\_\_\_\_

# VB Disability Claim Form Employee Statement



Have you returned to work?  Yes  No If yes, date returned \_\_\_\_\_ Full-time  Part-Time

Are you employed with any other company other than the Employer listed above? Yes No

(If yes, please submit Disability Employer Statements from **ALL** employers)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Dates Worked \_\_\_\_\_ Phone No. \_\_\_\_\_

## Physician information:

Attending (Treating) physicians:

Physician's Name	Address	Phone / Fax Number

Have you ever been treated for the same or a similar condition in the past? Yes  No

If yes, provide the prior Physician's Information:

Physician's Name	Address	Phone / Fax Number

## Other Income Information:

Please indicate any additional income you are currently receiving:

Yes	No	Type	Amount	Frequency	Date Began	Date Ceased
		Social Security (Disability or Retirement)	\$ _____	_____	_____	_____
		State Disability	\$ _____	_____	_____	_____
		Retirement (normal, early or disability)	\$ _____	_____	_____	_____
		Worker's Comp/Occupational Disease	\$ _____	_____	_____	_____
		Group Disability	\$ _____	_____	_____	_____
		Salary	\$ _____	_____	_____	_____

If you are not receiving these benefits, do you plan on applying or have you applied for benefit(s) described above?

Yes  No

Benefit Type \_\_\_\_\_ Date Applied \_\_\_\_\_

Benefit Type \_\_\_\_\_ Date Applied \_\_\_\_\_

# VB Disability Claim Form Employee Statement



## Deduction of Premium

To keep your policy active premiums can be deducted from your disability benefit payments. By deducting premiums this will ensure that your policy stays current and eliminates the risk of your policy terminating for non- payment of premiums. To prevent claim delays, please check your selection below.

No, I do not want my premiums deducted from my disability benefit

Yes, I want my premiums deducted from my disability benefit

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 11)

**The above Statements are true to the best of my knowledge and belief.**

\_\_\_\_\_  
**Signature of Policyholder**

\_\_\_\_\_  
**Date**



- Sign and date the authorization on page 7 and include when returning the claim form
- If the disability date is within the first year of the policy, complete the information on page 4 and return with the claim form.

**VB Disability Claim Form**  
**Employee Statement**



**If the claim is being filed for a disability within the first year of the policy, complete both the physician and medication information below:**

**Physician information:**

List all physicians that treated the patient in the five years prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

**Medication information:**

List all medication being taken by you:

Medication	Prescribing Physician	Date Prescribed

# Direct Deposit Authorization



### Check Action

New Change Cancel

### Account Type

Checking Savings

### Ownership of Account

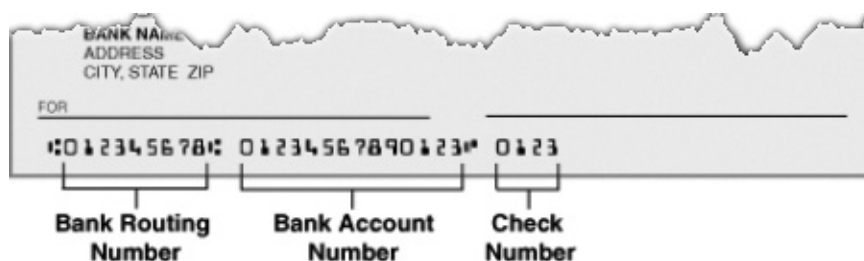
 

Self Other

Bank Name \_\_\_\_\_

Bank Routing Number \_\_\_\_\_ Bank Account Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_



## Terms and Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program, please read the following terms and conditions for participation carefully before making your decision. Not all policies may qualify.

1. Once the Form is received by ManhattanLife Insurance Co., **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife Insurance Company of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be canceled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife Insurance Co. or cannot be made to your account, ManhattanLife Insurance Co. will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be canceled by your financial institution or ManhattanLife Insurance Co. **Your participation will be canceled automatically if you terminate participation in the above Account(s).**

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife Insurance Company to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

**Authorization to Release Information**

For the Use and Disclosure of Protected Health Information



**Patient's Name** \_\_\_\_\_ **Policy No.** \_\_\_\_\_

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

**I authorize the use and/or disclosure of my protected health information and other related information as described below:**

- 1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
- 2. I authorize all health care professionals to disclose my protected health information to ManhattanLife Insurance Company,
- 3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
- 4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
- 5. I authorize only designated staff of ManhattanLife Assurance Company of America or ManhattanLife Insurance Company to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
- 6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
- 7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Attn: Claims Department PO Box 926169 Houston, TX 77292 . This revocation shall become effective on the date it is received by ManhattanLife Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.  
A photocopy or facsimile of this authorization shall be valid as the original.

<i>Signature</i>	<i>Printed Name</i>	<i>Date</i>
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I have legal authority\* under the laws of the State of \_\_\_\_\_ to make health care decisions on behalf of \_\_\_\_\_, the individual to whom the use and/or disclosure of protected health information above applies and execute this Authorization in my capacity as Authorized Representative thereof.

<i>Name of Authorized Representative/Parent or Guardian</i>	<i>Relationship to Applicant</i>	<i>Date</i>
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\*A copy of the legal authority document must be on file with ManhattanLife.

# VB Disability Claim Form

## Employer Statement



All questions must be completed by your Supervisor or an authorized Personnel Dept. staff member.

### Employee Information:

Employee's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy No. \_\_\_\_\_ Current Annual Base Salary\* \_\_\_\_\_

Does the employee receive commissions? Yes  No  \*Not including overtime pay, bonuses, commissions, or extra compensation

If yes, how much did the employee make in commissions in the last 12 calendar months? \_\_\_\_\_

### Claim Information:

Date Employee Last Worked: \_\_\_\_\_

Reason for stopping work:  Sickness  Granted LOA  Laid Off  Accident  Dismissed  
 Resigned  Retired  Other \_\_\_\_\_

Has the employee returned to work?  Yes  No  Part-time Date \_\_\_\_\_  
 Full-time Date \_\_\_\_\_

If No, what is the anticipated return to work date \_\_\_\_\_

Is this a Section 125 Plan? (If YES is selected taxes will be taken out of the employee's disability checks)  Yes  No

Employee's percentage of premium contribution: Employee pays 100 % Employer pays 0 %

Is the Employee receiving any form of salary continuance while on disability?  Yes  No

If yes, weekly benefit amount \_\_\_\_\_ Date benefits cease \_\_\_\_\_

Is the Employee's condition work related or did the injury occur at work? Yes  No

If Yes, has a Worker's Compensation or Occupational Disease claim been filed? Yes\*  No

\*if yes, include a copy of the accident report

Is the Employee allowed to work from their home? Yes  No

Is there light work available for the Employee to do? Yes\*  No

\*if yes, explain on the line below

Explain: \_\_\_\_\_  
 \_\_\_\_\_

What are the major tasks of the Employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks. Also, submit a job description.

\_\_\_\_\_  
 \_\_\_\_\_ %  
 \_\_\_\_\_ %  
 \_\_\_\_\_ %

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Applications or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State specific fraud statements on page 11).

**The above Statements are true to the best of my knowledge and belief.**

Employer's Name Livingston Parish Public Schools Phone No. 225.686.4230

Address PO Box 1130, Livingston, LA 70754 Fax No. 225.686.4363

Printed Name of Person Completing Form Erin D. Woodrich

Signature of Authorized Representative \_\_\_\_\_

Title Insurance Clerk Email erin.woodrich@lpsb.org Date \_\_\_\_\_

# VB Disability Claim Form Physician Statement



## Disability Information:

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Is the disability related to:  Illness  Pregnancy  Accident  Mental/Nervous Condition

Date you advised the patient they should cease work: \_\_\_\_\_

If pregnancy, Estimated Delivery Date: \_\_\_\_\_ Delivery Date \_\_\_\_\_  Vaginal  Cesarean Section

Estimated date of inception (Conception): \_\_\_\_\_

For conditions other than pregnancy, the date symptoms first appeared, or accident occurred: \_\_\_\_\_

Is the condition due to an injury or sickness arising from the patient's employment? Yes  No  Unknown

## Treatment Information:

Diagnosis (including any complications) \_\_\_\_\_

Diagnosis Code(s) (ICD-9/10) \_\_\_\_\_ If mental health diagnosis, complete the DSM-IV-TR axis section below:

Axis I \_\_\_\_\_ Axis II \_\_\_\_\_ Axis III \_\_\_\_\_ Axis IV \_\_\_\_\_ Axis V \_\_\_\_\_ GAF, or the DSM-V; WHODAS 2.0 Score \_\_\_\_\_

Date Assessed \_\_\_\_\_

Date of Patient's first visit for this condition \_\_\_\_\_ Date of last patient visit \_\_\_\_\_

Frequency of visits: Weekly Monthly Other(specify) \_\_\_\_\_

Objective findings (including current x-rays, EKG, laboratory data, any clinical findings and complications) \_\_\_\_\_

Patient's progress: Recovered Improved Patient is currently: Ambulatory House Confined  
Unchanged Regressed Bed Confined Hospital Confined

Current treatment plan for this condition (including any rehab program/medications) \_\_\_\_\_

Have any medications been changed?  Yes  No If yes, Date changed \_\_\_\_\_

Medication change: \_\_\_\_\_

Have any surgeries already been performed?  Yes  No If yes, Date \_\_\_\_\_

CPT Code(s)/procedure performed \_\_\_\_\_

If No, are there any surgeries scheduled?  Yes  No If yes, Date \_\_\_\_\_

CPT Codes(s)/procedure scheduled \_\_\_\_\_

Has the patient been hospital confined?  Yes  No If yes, Date \_\_\_\_\_

Discharge Date \_\_\_\_\_

Hospital Name: \_\_\_\_\_ Address \_\_\_\_\_

Has the patient ever had the same or similar condition?  Yes  No

If yes, indicate the type of condition, treatment date(s) and treatment provided: \_\_\_\_\_

Please provide the name and address of other treating physician(s):

Physician's Name	Address	Phone Number



# VB Disability Claim Form Physician Statement



ManhattanLife<sup>™</sup>

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Impairment:**

Cardiac Functional Capacity Limitations(American Heart Association -if applicable):  
 To be completed for cardiac disability

Class 1(none)	Class 2 (slight)
Class 3(marked)	Class 4(complete)

Blood Pressure (Last Visit) \_\_\_\_\_ Comments \_\_\_\_\_

Physical Impairments (As defined in Federal Dictionary of Occupational Titles)

- Class 1 – No limitation of functional capacity, capable of heavy work. No restriction (0%-10%)
  - Class 2 – Medium manual activity (15%-30%)
  - Class 3 – Slight limitation of functional capacity; capable of light work (35% - 55%)
  - Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity (60%- 70%)
  - Class 5 – Severe limitation of functional capacity; capable of minimum sedentary activity (75% - 100%)
- Comments: \_\_\_\_\_  
 \_\_\_\_\_

Mental Impairments (To be completed for Mental Health disabilities)

- 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 interpersonal relations (Slight limitations)
  - Class 3 – Patient is able to engage in only limited stress situations and engage in 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)
- Comments: \_\_\_\_\_  
 \_\_\_\_\_

**Functional Ability**

Estimate your patient's ability to perform the following tasks based on your knowledge of the patient on an average working day.

Activity:	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Number of Hours (less than 25%, 50%, 75%, 100%)
Standing					_____
Walking					_____
Sitting					_____
Kneeling					_____
Twisting/bending/stooping					_____
Reaching above shoulder level					_____
Operating heavy machinery					_____
Keyboard Use					_____
Repetitive Hand Motion					_____

Lifting/Carrying				Pushing/Pulling			
Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)

- Up to 10lbs
- 11 to 20lbs
- 21 to 50lbs
- 51 to 100lbs

**VB Disability Claim Form**  
**Physician Statement**



Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Prognosis and Restrictions:**

Is the patient currently disabled from their job?  Yes  No

If the patient works from their home, would this change their disability status or length of the disability?  
 Yes  No

If yes, please explain: \_\_\_\_\_

When do you expect a fundamental or marked change in the patient's condition?  
Less than 1 month    1 month    2-3 months    4-6 months    Other

What date can employment resume? \_\_\_\_\_ Full-time    Part-time

What date can employment resume in another occupation? \_\_\_\_\_ Full-time    Part-time

If the return to work date is unknown at this time, please indicate date of next appointment: \_\_\_\_\_

Describe fully how the patient's condition/limitations are affecting their ability to work, including any physical restrictions\*

**\* For pregnancy related disability: If filing disability prior to delivery, please submit medical records and flow charts.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If terminal, what is the life expectancy:  
6 months or less    9 months or less    12 months or less    Greater than 12 months

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 11)

***The above statements are true to the best of my knowledge and belief.***

Printed Name of Physician \_\_\_\_\_ Phone No. \_\_\_\_\_  
Specialty \_\_\_\_\_ Tax ID \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Fax No. \_\_\_\_\_  
Email Address \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Date \_\_\_\_\_

## State Specific Fraud Warning Statements

### ManhattanLife

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

**Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:** Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

**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.

**Arkansas, Louisiana, 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.

**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.

**California:** For your protection California law requires the following statement to appear on this form: Any person who knowingly presents 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

**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.

**Kentucky, 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.

**Kansas:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

**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.

**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 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 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.

**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.