Long Term Disability
Notice of Claim Package

Greater Georgia Life Insurance Company

EMPLOYER NOTICE OF CLAIM – INSTRUCTIONS

At approximately 45 days before end of benefit waiting period:

A. Complete the Employer's Statement in full.

Include:

- Job description
  (detailed duties, including physical requirements)
- Documentation of earnings in accordance with your plan description
- Workers' Compensation information
  (copy of first report of accident and the decision if any has been determined at this time)

B. Give forms to claimant for completion. These forms should be forwarded to the address shown below.

- All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.
- Any questions about these claim filing procedures should be referred to:

Greater Georgia Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 800-232-0113 Fax: 800-850-0017
E-mail: disability@wellpoint.com

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Long Term Disability Claim Form
Employer Statement

Notice to Customers Regarding Telephone Service Observance

To ensure our customers receive quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

EMPLOYEE INFORMATION

1 Employee name (last, first, M.I.)	2 Social Security no.	3 Birthdate (MM/DD/YYYY)	
4a Street address	4b City	4c State	4d ZIP code
5 Policy no.	6 Class	7 Phone no	

EMPLOYMENT

8 Employee date of hire	9 Effective date of LTD coverage	10 Date employee last worked full-time	11 Work schedule at time last worked
			No. of days per week: _____
12 Occupation at time last worked (Attach job description.)			No. of hours per day: _____

13 Reason for leaving work: ☐ Sickness ☐ Granted LOA ☐ Laid off ☐ Retired ☐ Dismissed ☐ Resigned ☐ Vacation ☐ Other

14 Has employee returned to work? ☐ Yes ☐ No
☐ Part-time – Date: _____ ☐ Full-time – Date: _____

INCOME

15 How is employee paid? ☐ Straight salary ☐ Salary and commission ☐ Commissions only ☐ Salary and bonus ☐ Hourly

16 Employee's basic monthly earnings
$ _____
LTD benefit _____
If salary is based on less than 12 months: No. of months: _____

17 Employee's percentage of LTD premium contribution: Employee pays: _____% ☐ Pre-tax ☐ Post-tax
Employer pays: _____%

OTHER BENEFITS

18 Has insured received other disability payments since time last worked?

Salary Continuance: ☐ Yes ☐ No
If yes, weekly amount: _____
Date benefits cease _____

Short Term Disability: ☐ Yes ☐ No
If yes, weekly amount: _____
Date benefits cease _____

Other Type: _____ ☐ Yes ☐ No
If yes, weekly amount: _____
Date benefits cease _____

19 Did claim result from job activity? ☐ Yes ☐ No
If yes, explain: _____

20 Has Workers' Compensation claim been filed? ☐ Yes ☐ No
☐ Pending ☐ Denied (enclose copy)

21 Workers' Compensation weekly amount
$ _____ Include a copy of first report of accident.

RETIREMENT

22 Is employee covered by a sponsored retirement plan? ☐ Yes ☐ No

23 Does the retirement plan contain a disability provision? ☐ Yes ☐ No

24a Is employee or will this employee be eligible for a disability or retirement pension? ☐ Yes ☐ No	24b If yes, type: ☐ Disability ☐ Retirement ☐ Other _____	24c Monthly amount $ _____	24d Date benefits commence

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.

CERTIFICATION

25 Employer name	26 Employer phone no.	27 Certificate no.	
28a Employer street address	28b City	28c State	28d ZIP code
29 Printed name of authorized company representative	30 Title		
Signature of authorized representative **X**		Date (MM/DD/YYYY)	

Separate and send this form (with other enclosures) to the address shown on the front page. Give the remaining forms to the claimant.

The laws of some states require us to provide you with the following information:

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, Louisiana, and 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.

California: For your protection California 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 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 and Idaho: 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 containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing 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.

Maine, Tennessee, Virginia, and 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 may include imprisonment, fines or denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps to 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 N.H. Rev. Stat. Ann. §638:20.

New Jersey: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: A 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 materials 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 violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and 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.

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.

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.

Long Term Disability Claim Form
Employee Statement

EMPLOYEE STATEMENT

1 Employee name (last, first, M.I.)	2 Social Security no.	3 Birthdate (MM/DD/YYYY)

4a Street address	4b City	4c State	4d ZIP code	5 Phone no.	6 Sex: ☐ Male ☐ Female

7 Height	8 Weight	9 Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	10 Spouse first name	11 Spouse birthdate (MM/DD/YYYY)	12 Is spouse employed?

13 List unmarried children who have not yet finished high school

Name	Birthdate (MM/DD/YYYY)	Name	Birthdate (MM/DD/YYYY)

14 Employer name	16 Level of education	Degree Earned
15 Group policy no.	*(please check proper box)* Grade school/High school: 1 2 3 4 5 6 7 8 9 10 11 12	☐ College: _____ ☐ Graduate: _____

EMPLOYMENT

17 Occupation (List the duties of your occupation at the time of disability.)

18 Date of accident or date first noticed symptoms of illness (MM/DD/YYYY)	19 I have been unable to work because of the disability since (MM/DD/YYYY)	20 I returned to work on a part-time basis on (MM/DD/YYYY)	21 I returned to work on a full-time basis on (MM/DD/YYYY)

22 Is your accident or illness related to your occupation? ☐ Yes ☐ No	23a If yes, explain:	23b Have you, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

CLAIMS HISTORY

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

☐ Auto ☐ Work ☐ Home ☐ Other _____

25 Date you were first treated for this illness or injury (MM/DD/YYYY):

26 Treated by	Hospital name			
	Street address	City	State	ZIP code
	Doctor name			
	Street address	City	State	ZIP code

27 Have you ever had the same or similar condition in the past? ☐ Yes ☐ No **If yes, complete no. 28.**

28 Treated by	Hospital name			
	Street address	City	State	ZIP code
	Doctor name			
	Street address	City	State	ZIP code

Long Term Disability Claim Form
Employee Statement *(continued)*

INCOME

Yes	No		Amount	Date began (MM/DD/YYYY)	Date terminated (MM/DD/YYYY)
☐	☐	Social Security (disability or retirement)	$		
☐	☐	State disability	$		
☐	☐	Retirement (normal, early or disability)	$		
☐	☐	Workers' Compensation	$		
☐	☐	Group disability benefits	$		
☐	☐	Other (describe):	$		

BENEFITS

30 Have you, or do you plan to apply for any benefits described above? ☐ Yes ☐ No	Type	Date application filed (MM/DD/YYYY)

31 If your request for benefits is approved do you want us to withhold amounts from each benefit check for federal income tax purposes? ☐ Yes ☐ No	If yes, what amount? (Indicate amount per month, $88.00 minimum.) $
32 If your request for benefits is approved do you want us to withhold amount from each benefit check for state tax purposes? ☐ Yes ☐ No	If yes, what amount? (Indicate amount per month, $88.00 minimum.) $

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false or misleading information may be subject to criminal penalties.

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

Employee signature	Date (MM/DD/YYYY)
X	

Long Term Disability
Employee Authorization for Release of Information

AUTHORIZATION TO BE COMPLETED BY CLAIMANT

AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Georgia Life Insurance Company (Georgia Life) and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Georgia Life representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Georgia Life solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Georgia Life in writing, of my revocation. However, such revocation is not effective to the extent that Georgia Life have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Georgia Life's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING GEORGIA LIFE to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Georgia Life shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant printed name	Birthdate (MM/DD/YYYY)

Claimant signature **X**	Date (MM/DD/YYYY)

Relationship of authorized person	Description of personal representative's authority, if applicable (If signed by authorized representative, attach verification of identity.)

Send completed form to:

Georgia Life Insurance Company
Disability Claim Service Center – LTD Unit
P.O. Box 105426
Atlanta, GA 30348-5426

For customer service:

Call: 800-232-0113
Fax: 800-850-0017

Long Term Disability Claim Form
Attending Physician's Statement

HISTORY

Patient name (last, first, M.I.)		Birthdate (MM/DD/YYYY)
Date symptoms first appeared or accident happened (MM/DD/YYYY)	Date patient ceased work because of disability (MM/DD/YYYY)	Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe:
Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown	Names and addresses of other treating physicians	

DIAGNOSIS (If disabling condition is due to a mental or nervous disorder, the attached *Functional Capabilities Evaluation* and *Mental Status Questionnaire* sections must also be completed.)

Diagnosis (including complications)	Subjective symptoms	If pregnancy, estimated date of delivery
Objective findings (including current X-rays, EKGs, laboratory data and any clinical findings)		

TREATMENT

Date of first visit (MM/DD/YYYY)	Date of last visit (MM/DD/YYYY)	Frequency ☐ Weekly ☐ Monthly ☐ Other: _____
Nature of treatment (Including surgery and medications prescribed, if any)		

PROGRESS

Patient's present condition	Is patient?	Is patient mentally competent to endorse checks and direct proceeds thereof?
☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined	☐ Yes ☐ No

Has patient been hospital confined? ☐ Yes ☐ No If yes, please complete the following:

Hospital name	Confined from (MM/DD/YYYY)	Through (MM/DD/YYYY)	
Hospital address	City	State	ZIP code

CARDIAC

Functional capacity (American Heart Association)	Blood pressure last visit
☐ Class 1 (no limitations) ☐ Class 2 (slight limitations) ☐ Class 3 (marked limitations) ☐ Class 4 (complete limitations)	_____/_____ (systolic/diastolic)

IMPAIRMENTS

Physical impairments (*As defined in ***Federal Dictionary of Occupational Titles***.)

☐ Class 1 – No limitations of functional capacity; capable of heavy work* no restrictions (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; incapable of minimum (sedentary*) activity (75-100%)

Remarks:

Long Term Disability Claim Form
Attending Physician's Statement *(continued)*

IMPAIRMENTS (continued)

Mental Impairments (if any):

a. Please define "stress" as it applies to this claimant and in light of his/her job requirements.

b. What stress and problems in interpersonal relations has claimant had on 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)

REHAB

Is patient a suitable candidate for occupational rehabilitation?

☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never

When could trial employment commence?

Patient's Own Job (MM/DD/YYYY) ☐ Full-time ☐ Part-time

Any Other Work (MM/DD/YYYY) ☐ Full-time ☐ Part-time

ANY ADDITIONAL REMARKS

Limitations, therapy, etc.

Printed attending physician name	Degree	Phone no.	
Street address	City	State	ZIP code
Signature **X**		Date (MM/DD/YYYY)	

Long Term Disability Claim Form
Mental Status Questionnaire *(Needs to be completed only if condition is due to mental or nervous disorder)*

PATIENT INFORMATION

Patient name (last, first, M.I.)		
Date treatment began (MM/DD/YYYY)	Frequency	Nature of treatment
Diagnosis (Use DSM IV Multi-axial evaluation nomenclature and code numbers)		

PLEASE RESPOND TO ALL ITEMS. USE ADDITIONAL PAGES AS NECESSARY.

State patient's initial reason for seeking treatment.
Describe patient's current condition and mental status.
Medications: Please list current medications, dosage and dates begun.
Please summarize current treatment goals.
Comments

Physician signature	Date (MM/DD/YYYY)

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Atlanta, GA 30348-5426

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