Liberty National Life Insurance Company

Insurance Services Division • P.O. Box 8066 • McKinney, TX 75070

CLAIM FOR PREMIUM WAIVER

CLAIM FOR TOTAL DISABILITY/PREMIUM WAIVER BENEFITS

Please carefully read all of the following information before completing this statement.

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.

Arkansas, Louisiana, Rhode Island, Texas 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.

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.

California: For your protection California law requires that you be made aware of the following: 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 a 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 or 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.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly or 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: 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 a denial of insurance benefits.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.

New Hampshire: Any person who, with a purpose to inure, 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: Any person who knowingly files a statement of claim containing any false or misleading information 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.

Ohio: Any person who, with 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 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.

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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.

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 include imprisonment, fines and denial of insurance benefits.

Liberty National Life Insurance Company

Insurance Services Division • P.O. Box 8066 • McKinney, TX 75070
Fax: 214-250-5141 • email: custserv@libnat.com

CLAIM FOR TOTAL DISABILITY/PREMIUM WAIVER BENEFITS

INSTRUCTIONS

1. If this is your **first** time to submit a request for Premium Waiver, you must complete and submit **all** sections and pages of this form.
2. If you are filing a request for the **continuance** of Premium Waiver benefits, **only** complete the **"Insured Information"** section below and submit this page along with the **"Attending Physician's Statement of Disability"** (page 3), which should be completed by the Physician.

INSURED'S INFORMATION

Full Name ______________________________ Policy Number(s) ______________________________

Address ____
Street Address City State ZIP

Social Security # ____________________ Date of Birth ______________ Age _____ Height _____ Weight _____

Phone: Home ______________ Work ______________ Email ______________________________

HISTORY

1. Fully describe your present illness or injury :

____

____

2. When did this illness or injury begin (date)? ______________
3. Have you had this illness or injury, or one similar to it, before? Yes or No? _____ If yes, please provide date ______________
4. Please provide names and addresses of all physicians you have seen due to this condition:

____

____

5. Have you been confined to a hospital as a result of this illness or injury? Yes or No? _____ If yes, provide confinement dates
______________ to ______________
Also, provide the name and address of the hospital ______________________________
6. Have you filed for Social Security Disability? Yes or No? _____ If yes, please submit a copy of either your award or denial letter. If you were denied, are you appealing the decision? Yes or No? _____

EMPLOYMENT

1. Name, address, and phone number of your employer when you became unable to work:

____

2. How long did you work for this employer? __________ Name of immediate supervisor? ______________________
3. What was your occupation? ____________ When did this illness or injury cause you to cease to work (date)? ______________
4. Is this injury or illness the result of your employment? Yes, No, or Unknown? __________ If YES, have you filed a claim for Worker's Compensation? Yes or No? _____ Please provide the name and address of the Worker's Compensation Carrier:

____

ACTIVITIES

1. As a result of this injury or illness are you: _____ House Confined? _____ Bed Confined? _____ Hospital Confined? _____ Wheelchair Confined?
2. What are your daily activities? ______________________________
3. Does your illness or injury completely prevent you from engaging in any occupation for compensation? Yes or No? _____

Signature of Insured ______________________________ Date Signed ______________

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

This statement should be completed by the Insured's Physician.

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Insured's Name ______________________________ Date of Birth ______________ Policy Number ______________

Address ____
Street City State ZIP

DIAGNOSIS

1. Diagnosis ____ 2. Date of diagnosis ______________
3. Subjective symptoms ____
4. Objective findings (including current X -Rays, EKG's, Lab Data and any other clinical findings):

____

5. Is there a previous history of this illness or injury? ☐ Yes ☐ No If "Yes", state when and describe:

____

PROGRESS

1. Has patient: ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
2. Is patient: ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
3. Has patient been hospital confined? ☐ Yes ☐ No If "Yes", give name and address of hospital:

____

4. Dates of confinement: Admitted ______________ Discharged ______________

CARDIAC (IF APPLICABLE)

1. Function capacity ☐ Class 1(no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)
2. Blood pressure reading (last visit) __________/__________
Systolic Diastolic

PHYSICAL IMPAIRMENT

☐ Class 1- no limitation; capable of heavy activity (0-10%)
☐ Class 2 - slight limitation; capable of light activity (15-30%)
☐ Class 3 - moderate limitation; capable of sedentary activity (35-55%)
☐ Class 4 - marked limitation (60-70%)
☐ Class 5 - severe limitation; incapable of sedentary activity (75-100%)

MENTAL/ NERVOUS IMPAIRMENT (IF APPLICABLE)

☐ Class 1- can function under stress (no limitations)
☐ Class 2 - can function under most stress situations (slight limitations)
☐ Class 3 - can engage in limited stress situations (moderate limitations)
☐ Class 4 - cannot engage in stress situations (marked limitations)
☐ Class 5 - patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

VISUAL IMPAIRMENT

1. Is insured totally blind? ☐ Yes ☐ No **(Snellen Notation)**
2. If not totally blind, what was vision at last observation? With Glasses O.D. ________ O.S.________ Date: ______________
Without Glasses O.D. ________ O.S.________ Date: ______________
3. What is the extent of any gross visual field defect? ______________ 4. Can vision be improved by treatments, operation, or lenses? ☐ Yes ☐ No

PROGNOSIS

	Patient's Job	Any Other Work
1. Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you expect a marked change in the future?	☐ Yes ☐ No	☐ Yes ☐ No

a) If "Yes", when will patient recover sufficiently to perform duties?
b) If "No", please explain: ____

______________________________ ______________________________
Physician's Name (PRINT) Physician's Signature

____
Street Address City State ZIP

______________________________ ______________________________
Fax Number Phone Number

R3811 **0416**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Insured's Name:	Date of Birth:	Social Security Number:	Policy Number:
Insured's Address:			

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the below named entity and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and Instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization in order to: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the entity named below at the address also listed. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the named entity has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, my claim may not be able to be processed and receive benefits potentially owed. I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent:

Liberty National Life Insurance Company.
PO Box 8066
McKinney, Texas 75070

If not the patient, name of person signing form:

Authority to sign on behalf of patient:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Child
- ☐ Spouse
- ☐ Next of Kin
- ☐ Executor of Estate
- ☐ Other (please specify relationship to insured) ____________________

IMPORTANT: If the patient is deceased, please **INITIAL** one of the statements below:

☐ I am the Administrator/Executor for the deceased and Letters of Testamentary, Executor of Estate documents, or other comparable documentation is enclosed.

☐ There is no court appointed Administrator/Executor and I am the Next of Kin.

All items on this form have been completed and my questions about this form have been answered, and I have been provided a copy of this form.

Signature of patient or personal representative: ____________________ Date Signed: __________