

Underwritten by Liberty National Life Insurance Company, a Globe Life company

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, 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 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: 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 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 NH 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.

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.

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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's 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

Fully describe your present illness or injury _____

When did this illness or injury begin (date)? _____

Have you had this illness or injury, or one similar to it, before? Yes No If yes, please provide date _____
Please provide names and addresses of all physicians you have seen due to this condition _____

Have you been confined to a hospital as a result of this illness or injury? Yes No

If Yes, provide confinement dates _____ to _____

Also, provide the name and address of the hospital _____

Have you filed for Social Security Disability? Yes No If yes, please submit a copy of either your award or denial letter.

If you were denied, are you appealing the decision? Yes No

Employment

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

How long did you work for this employer? _____ Name of immediate supervisor? _____

What was your occupation? _____ When did this illness or injury cause you to cease to work (date)? _____

Is this injury or illness the result of your employment? Yes No Unknown

If Yes, have you filed a claim for Workers' Compensation? Yes No

Please provide the name and address of the Workers' Compensation Carrier _____

Activities

As a result of this injury or illness are you: House Confined Bed Confined Hospital Confined Wheelchair Confined

What are your daily activities? _____

Does your illness or injury completely prevent you from engaging in any occupation for compensation? Yes No

Signature of Insured

Date Signed

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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 Address City State ZIP

Diagnosis

Diagnosis _____ Date of diagnosis _____

Subjective symptoms _____

Objective findings (including current X -Rays, EKG's, Lab Data and any other clinical findings) _____

Is there a previous history of this illness or injury? Yes No

If "Yes", state when and describe _____

Progress

Has patient: Recovered Improved Unchanged Retrogressed

Is patient: Ambulatory House confined Bed confined Hospital confined

Has patient been hospital confined? Yes No

If "Yes", give name and address of hospital _____

Dates of confinement: Admitted _____ Discharged _____

Cardiac (If Applicable)

Function capacity:

- Class 1 – no limitation
- Class 2 – slight limitation
- Class 3 – marked limitation
- Class 4 – complete limitation

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%)

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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

Is insured totally blind? Yes No

If not totally blind, what was vision at last observation? (Snellen Notation below)

With Glasses O.D. _____ O.S. _____ Date _____

Without Glasses O.D. _____ O.S. _____ Date _____

What is the extent of any gross visual field defect? _____

Can vision be improved by treatments, operation, or lenses? Yes No

Prognosis

	Patient's Job	Any Other Work
Is patient now totally disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you expect a marked change in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. If "Yes", when will patient recover sufficiently to perform duties?

2. If "No", please explain _____

Physician's Name (PRINT)

Physician's Signature

Address _____
Street Address City State ZIP

Fax Number

Phone Number



LN Life Claims Department
 PO Box 8066
 McKinney, TX 75070-8066
 f.: 214-250-5141 | LNAgentService@Globe.Life

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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 I 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 redisclosed 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:		
<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Next of Kin
<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Executor of Estate
<input type="checkbox"/> 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