DISABILITY CLAIM FORM

Fidelity Security Life Insurance Company®
3130 Broadway, Kansas City, MO 64111
Phone: (800) 648-8624 • (816) 756-1060
Fax: (816) 968-0575 • Email: Claimsmail@ftj.com

MAIL TO: Fidelity Security Life Insurance Company
P.O. Box 418131
Kansas City, MO 64141-8131

INSURED'S STATEMENT

CHECK LIST

1. Completed Insured's Statement ☐	3. Completed Attending Physician Statement ☐
2. Sign and date Authorization ☐	4. Completed Employer Statement ☐

INSURED'S INFORMATION

Name of Insured: (Last Name) (First Name) (MI)	Date of Birth:	Height:	Weight:	Sex: ☐M ☐F
Address: (Street) (City) (State) (Zip)				Telephone Number:
Policy Number	Social Security Number			

CURRENT DISABILITY INFORMATION

Date of Accident or Beginning of Sickness	Last Date(s) Worked	Date(s) Returned to Work	Date You Plan to Return to Work

Nature of Sickness or Injury	If Injured, How, When and Where Did Accident Happen? ***Attach a separate sheet with details.**
	MVA ☐ Yes ☐ No If "Yes", attach copy of police accident report.
Current Physician's Name, Address, Telephone Number	Name, Address, Telephone Number of First Physician Consulted:
	Date Consulted:

EMPLOYMENT INFORMATION

Employer Name	Address	City	State	Zip	Telephone No.

Occupation	Gross Monthly Earnings	Did Disability arise out of employment? ☐ Yes ☐ No

As closely as possible, please estimate the percent of time spent on the following activities in your job:

Sitting _____ Standing _____ Walking _____ Climbing _____ Stooping _____
Bending _____ Pushing _____ Lifting* _____ _____ Carrying* _____ _____
Avg. Max. Avg. Max.

**If job duties require lifting or carrying, indicate average and maximum weights handled.*

MEDICAL HISTORY INFORMATION

Complete names and mailing addresses of all doctors, hospitals or clinics who have treated the patient within the past 5 years. This should include those who have treated you for ANY condition, including routine physicals or examinations. If more space is needed, please use a separate sheet of paper.

Physician/Doctor Name	Address	Telephone No.	Dates	Condition

OTHER INSURANCE INFORMATION

Are You entitled to benefits from any of the following for this Disability?
☐ Yes ☐ No ☐ Not Sure, explain._____

☐ Workers' Compensation (Attach copy of award letter)
☐ Salary Continuance
☐ Social Security (Attach copy of award letter)
☐ Any Other Government Agency
☐ Other Disability Income Plans

If Yes, Please Provide the Following Information:

Monthly Benefit	Date Benefit Began	Maximum Payment Period	Policy Effective Date	Insurance Carrier's Name, Address and Telephone Number

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he or she 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. *****NOTICE – See State-Specific Fraud Notices included with this form*****

I certify that the information given by me in support of this claim is true and correct.

Insured's Signature _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form. We must have comprehensive medical information in order to evaluate the insured's claim for Disability Benefits

Mail To: Fidelity Security Life Insurance Company
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Patient's Name:	Social Security Number:	Age:
Present Address: Street	City	State Zip

1. **HISTORY**
   (a) When did symptoms first appear or accident happen? Month____ Day____ 20____
   (b) Date disability commenced. Month____ Day____ 20____
   (c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe.
   (d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

2. **DIAGNOSIS:**
   Primary disabling diagnosis:____ ICD-9 Code____
   Secondary contributing diagnosis, if any:____ ICD-9 Code____

3. **DATES OF TREATMENT**
   (a) Date of first visit: Month____ Day____ 20____
   (b) Date of last visit: Month____ Day____ 20____
   (c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify)____

4. **NATURE OF TREATMENT (Including surgery and medications prescribed, if any)**
   Will treatment substantially improve function and employability? ☐ Yes ☐ No
   If "Yes", specify.____
   Name, address, telephone number of other treating providers:____

5. **PROGRESS**
   (a) Has patient: ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
   (b) Is patient: ☐ Bed confined? ☐ Hospital Confined? ☐ Ambulatory? ☐ House confined?
   (c) Has patient been hospital confined? ☐ Yes ☐ No If "Yes", give name and address of hospital.
   Hospital confined from ____ through ____
   House confined from ____ through ____

6. **CARDIAC (If applicable)**
   (a) Functional capacity. (*American Heart Association*)
   ☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
   (b) Blood Pressure (last visit). ____ Systolic ____ Diastolic

7. **LIMITATION (If there is a limitation, check and describe below)**
   ☐ Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Sitting
   ☐ Walking ☐ Stooping ☐ Lifting ☐ Psychological ☐ Other (state which)____
   If indicated above, are these restrictions permanent? ☐ Yes ☐ No

Please Complete Other Side

8. **PHYSICAL IMPAIRMENT (*As defined in Federal Dictionary of Occupation Titles)**

☐ Class 1 — No limitation 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 minimal (sedentary*) activity. (75-100%)

Remarks:

9. **MENTAL/NERVOUS IMPAIRMENT**

(a) Please define "stress" as it applies to this claimant.

☐ 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)

Remarks:

10. **EXTENT OF DISABILITY**

Dates of Total Disability: from _____ through _____

Dates of Partial Disability: from _____ through _____

Estimated Return to work date: _____

When do you expect a fundamental or marked change in the future: ☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never

11. **REHABILITATION**

(a) Is patient a suitable candidate for further rehabilitation services? ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

If "Yes", please describe modifications: _____

	Patient's Job		Any Other Work	
(c) When could trial employment commence?	___/___/___ Mo. Day Yr.	☐ Full-Time ☐ Part-Time	___/___/___ Mo. Day Yr.	☐ Full-Time ☐ Part-Time

12. **REMARKS**

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Physician's Name (print)	Individual Practitioner's Social Security No.
Degree	All Others – Employer I.D. No. (must be furnished under authority of law)
Physician's Signature	Date
Street Address / City/Town / State/Province / Zip	
Telephone Number	Fax Number

EMPLOYER STATEMENT

To be completed by the Employer

Insured Name	Social Security Number	Date of Birth	Sex: ☐ Male ☐ Female

Date Hired	Basic Earnings: _____ Week _____ Month	Occupation

As closely as possible, please estimate the percent of time spent on the following activities in your job:

Sitting _____ Standing _____ Walking _____ Climbing _____ Stooping _____
Bending _____ Pushing _____ Lifting* _____ (Avg.) _____ (Max.) Carrying* _____ (Avg.) _____ (Max.)

**If job duties require lifting or carrying, indicate average and maximum weights handled.*

Attach Job Description

Name of Employer	Division

Address (Street) (City) (State) (Zip)	Telephone Number

Last Date(s) Worked	Date(s) Returned to Work

Has Employee Been Terminated? ☐ Yes ☐ No

Date: _____

Reason: _____

_____

Has Employee Filed for Workers' Compensation Benefits? ☐ Yes ☐ No If "Yes", Please provide name, address and telephone number of Carrier.

_____

_____

Does Employer Have Group Disability Insurance on Employee? ☐ Yes ☐ No

Does Employer Have Payroll Deduction for a Disability Plan? ☐ Yes ☐ No If Yes, Please Provide the Following:

Name of Company	
Address (Street) (City) (State) (Zip)	Telephone Number

Policy Number	Weekly/Monthly Benefit

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THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Printed Name of Authorized Representative	Telephone Number/Extension

Signature of Authorized Representative	Date Signed

FIDELITY SECURITY LIFE INSURANCE COMPANY®
P.O. BOX 418131 • 3130 BROADWAY • KANSAS CITY, MO 64141-8131
800-648-8624 • 816-756-1060
FAX 816-968-0560 • Email: Claimsmail@ftj.com

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

I authorize the disclosure of health information regarding, or related to:

Name: _____ Date of Birth _____ Policy No. _____

Claim No. _____

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to: (i) communicable diseases, including HIV, AIDS or AIDS-related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations, business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Fidelity Security Life Insurance Company® ("FSL"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization to administer the above-referenced individual's health insurance coverage.

A photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below.

I understand that FSL and my providers may not condition payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64141-8131, Attention: Privacy Officer.

I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and once re-disclosed, may no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that I will receive a signed copy of this Authorization.

► _____ _____

Signature of the individual or the individual's personal representative — Date

If signed by the individual's personal representative (e.g., a parent on behalf of a child), describe your authority to sign on behalf of the individual.

GENERAL FRAUD NOTICE: NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he or she 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.

FRAUD NOTICE: For the states of AL, AZ, AR, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NH, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of 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.

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, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of 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.

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: 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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Georgia, Oregon, Vermont: Any person who with 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 guilty of insurance fraud.

Indiana: A 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.

Kansas: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

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.

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

Maine, Tennessee, 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 a denial of insurance benefits.

Nebraska: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.

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 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.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 state law.