# Globe Life And Accident Insurance Company

**Insurance Services Division • P.O. Box 8076 • McKinney, Texas 75070**

## DISABILITY/WAIVER OF PREMIUM — CLAIMANT'S STATEMENT

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.

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Insured's Name: _____ Policy Numbers:_____

Address: _____
Street City State ZIP

Social Security #: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Phone: Home _____ Work: _____ Email Address: _____

### HISTORY

1. Describe your present illness or injury fully: _____
   _____
2. When did this illness or injury begin (date)? _____
3. Have you had this illness or injury or one similar to it before? ☐ Yes ☐ No If "Yes", when (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 ☐ No If "Yes", please provide the name and address of the hospital and the date(s) of confinement:
   _____
6. 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

1. Name, address, & phone number of your employer when you became unable to work: _____
   _____
2. How long did you work for this employer? _____
3. Name of immediate supervisor: _____
4. What was your occupation?_____
5. When did this illness or injury cause you to cease work (date)?_____
6. Is this injury or illness the result of your employment? ☐ Yes ☐ No ☐ Unknown If "Yes", have you filed a claim for Workmen's Compensation? Please provide the name and address of Workmen's Compensation Carrier
   _____

Signature of Insured: _____ Date:_____

# ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

**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.**

Insured's Name: _____ Date of Birth: _____ Policy Numbers: _____

Address: _____
Street, City, State, ZIP

## DIAGNOSIS

1. Diagnosis:_____ 2. Date of diagnosis: Month _____ Day ____ Year _____
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 & 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: Month _____ Day ____ Year _____ Discharged: Month _____ Day ____ Year _____

## 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%)

## 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)** | **Street Address** | **City** | **State** | **Zip Code**

**Physician's Signature** | **Phone Number** | **Fax Number**

# 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 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, GL may not be able to process my claim or make any benefit payments. 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:

Globe Life And Accident Insurance Company
PO Box 8076
McKinney, TX 75070

Name of person signing form: _____

Authority to sign on behalf of patient:

☐ Parent ☐ Legal Guardian ☐ Next of Kin

☐ Child ☐ Spouse ☐ Executor of Estate

☐ Other (please specify relationship to insured): _____

**IMPORTANT**: If the patient is deceased, please INITIAL on 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: _____