MEDMUTUAL LIFE®
A Medical Mutual Company

100 American Road
Brooklyn, OH 44144-2322

Waiver of Premium Claim Form

Telephone: 866-925-2542
Fax: 440-878-6916
Email Address: Claims@medmutual.com

Group Number

Claimant's Statement *(Please print)*

Name	Social Security No.	Height	Weight	Date of Birth
				/ /

Address
Number Street City State Zip

Home Telephone Number
( )

Name of Employer	Occupation	Home Email Address (optional)

Are you filing a claim for this disability under the Workers' Compensation Act? ☐ Yes ☐ No
Are you filing a claim for this disability under the Social Security Act? ☐ Yes ☐ No

Please indicate if you are receiving income from any of the following:

	Amount	Date Benefit Began	Date Benefit Ended
☐ Social Security* (disability or retirement)	$_____	_____	_____
☐ State Disability	$_____	_____	_____
☐ Workers's Compensation	$_____	_____	_____
☐ Group Disability Benefits	$_____	_____	_____
☐ Retirement (normal, early or disability)	$_____	_____	_____
☐ Other (describe)	$_____	_____	_____

**Please include a copy of your award letter*

1. Date of Accident or Beginning of Sickness: ____ /____ /____ 2. Date Last Worked: ____ /____ /____
3. Nature of Illness or Injury: _____
4. If injury, describe how and where the accident occurred: _____
5. Have you ever had same or similar illness? ☐ Yes ☐ No If yes, give dates: From ____ /____ /____ to ____ /____ /____
6. Name of Hospital(s): _____ Confined From ____ /____ /____ to ____ /____ /____
   Address of Hospital(s): _____
7. Name and Address of Doctor(s): _____
8. Between what dates were you unable to work? From ____ /____ /____ to ____ /____ /____

I authorize my employer to access and/or disclose any information necessary to process my claim to MedMutual Life Insurance Company (MedMutual Life). I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to MedMutual Life's claim department or its authorized representative(s) information about my medical history or treatment for any condition, including but not limited to drug or alcohol abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases. I further authorize MedMutual Life to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.
I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on prior actions taken by MedMutual Life;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy is as valid as the original;

I, as well as any other person authorized to act on my behalf, acknowledge the right upon request to obtain a true copy of my authorization from MedMutual Life.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, MedMutual Life has the right to deny my claim. 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. (Not enforceable in Oregon or Virginia.)

_____ _____
Signature of Employee Date

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Employer's Statement

Employee's Name	Social Security No.	Hire Date	Insurance Eff. Date	Occupation

Employer's Name and Address	Amout of Weekly Disability Benefit

Date Last Worked	Date Returned	Base Salary	Hours Worked Per Week	Voluntary Buy-Up? ☐ Yes ☐ No If yes, amount: _____

Workers' Comp Claim Filed? ☐ Yes ☐ No	Amount of Life Insurance in Force:	Premium Paid to Date:

Claimant Received:	Through Date	Premium Contribution %
☐ Salary Continuation/PTO	____ /____ /____	Employer _____% Employee _____%
☐ Vacation	____ /____ /____	Employee's Premium for this Coverage Pre-Taxed? ☐ Yes ☐ No
☐ Sick Pay	____ /____ /____	

Signature	Title	Date	Telephone Number	Fax Number
			( )	( )

Attending Physician's Statement *(Please print)*

(Must be completed in full at no expense to MedMutual Life)

Patient's Name	Address	Date of Birth / /	☐ Male ☐ Female

1. Symptoms result from: ☐ Injury ☐ Illness
2. Is condition work related? ☐ Yes ☐ No
3. Diagnosis and complications, if any: _____ ICD9-CM _____
4. Date symptoms first appeared or date of accident: ____ /____ /____
5. Date patient first consulted you for this condition: ____ /____ /____
6. Most recent treatment date: ____ /____ /____
7. Describe any other disease or complications affecting present condition: _____
8. Date and nature of surgical or obstetrical procedure, if any: _____
9. If maternity, give estimated or actual date of delivery: ____ /____ /____ ☐ Estimated ☐ Actual ☐ Vaginal ☐ C-Section
10. Give all treatment dates and nature of treatment other than surgical: _____
11. Has patient been hospitalized? ☐ Yes ☐ No If yes, dates of confinement: ____ /____ /____ to ____ /____ /____
12. Name and address of hospital: _____
13. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, state when and describe: _____
14. Is patient still under your care? ☐ Yes ☐ No If no, give discharge date and degree of recovery: _____
15. Is patient under the care of another physician? ☐ Yes ☐ No If yes, provide name and address: _____
16. **Dates patient was/will be continuously disabled:**
    In his own occupation: ____ /____ /____ **to** ____ /____ /____ **In any occupation:** ____ /____ /____ **to** ____ /____ /____
17. **Patient can return to work on:** ____ /____ /____ ☐ Full Time ☐ Part Time ☐ With restrictions
    If applicable, describe part time hours/restrictions: _____
18. In your opinion, is patient able to perform another job on a full or part-time basis? ☐ Yes ☐ No
    If yes, advise number of hours/level of work capacity (ie sedentary, light duty, etc): _____
19. In your opinion, is patient a candidate for rehabilitation? ☐ Yes ☐ No
20. If patient is diagnosed as terminal, life expectancy is: ☐ 6 months or less ☐ 12 months or less ☐ Other _____

Physician Signature: _____ Date: ____ /____ /____

Name *(Please Print)*: _____ Specialty: _____

Address: _____

Telephone Number: _____ Fax Number: _____

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Fraud Notices

The laws of some states require us to furnish you with the following notice:

For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS – For your protection, California law requires the following to appear on this form. 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.

FLORIDA RESIDENTS – Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS – 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA and UTAH RESIDENTS – 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 materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.