

Claim Form

Telephone: 866-925-2542 Fax: 440-878-6916

Email Address: Claims@medmutual.com

100 American Road Brooklyn, OH 44144-2322

Type of Claim Being Submitted: Short	rt-Term Disability	☐ Waiver of	of Premiun	n 🗌 Accel	erated Death Benefit					
			Group Number							
Claimant's Statement (Please print)										
Name	Social Security No. Height		Height	Weight	Date of Birth					
					/ /					
Address				Но	ome Telephone Number					
Number Street	City	State	Zip	()					
Name of Employer	Occupation		Home Email Address (optional)							
Are you filing a claim for this disability under the W Are you filing a claim for this disability under the So	☐ Yes ☐ No ☐ Yes ☐ No									
Please indicate if you are receiving income from any	of the following:	Data Pana	ofit Dogon	Date Benefi	t Endad					
☐ Social Security* (disability or retirement)	\$	Date Bene	C	Date Bellett	t Ended					
☐ State Disability	\$									
☐ Workers's Compensation	\$									
Group Disability Benefits	\$									
Retirement (normal, early or disability)	\$									
Other (describe) *Please include a copy of your award letter	\$									
Date of Accident or Beginning of Sickness:	//_	2. Date Las	st 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/ 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?					o/					
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 unt ANY PERSON WHO KNOWINGLY AND WITH AN APPLICATION FOR INSURANCE OR STAT CONCEALS FOR THE PURPOSE OF MISLEAD A FRAUDULENT INSURANCE ACT, WHICH IS A enforceable in Oregon or Virginia.)	INTENT TO DEFRAU EMENT OF CLAIM (ING, INFORMATION	JD ANY INSUI CONTAINING A CONCERNING	RANCE COM ANY MATE BANY FAC	MPANY OR OΊ RIALLY FALS: Γ MATERIAL	THER PERSON FILES E INFORMATION OR THERETO COMMITS					
Signature of Emr	Signature of Employee									
Signature of Emp		Date								



Employer's Statement

Employee's Name		Social Security No.		Н	Hire Date		Insurance Eff. Date		Occupation		
Employer's Name and A	ddress							Amount o	of Week	ly Disability Benefit	
Date Last Worked Date Returned			Base Salary Hours Worked Per			Week	k Voluntary Buy-Up? Yes No				
								If yes, amount:			
Workers' Comp Claim I	Workers' Comp Claim Filed? Yes No			Amount of Life Insurance in Force:				Premium Paid to Date:			
Claimant Received:		Through D									
Salary Continuation		_//						%			
☐ Vacation ☐ Sick Pay	□ Vacation // □ Sick Pay //									Yes No	
Signature			Title	Date		Telephone Nu		mber		Fax Number	
_)	
Attending Physic	ian's Stat	ement (e to MedMutual Life			
Patient's Name	iun s stat	chiene ()	Address					Date of Birth			
Tationic 5 Tainio			Address						/	☐ Male ☐ Female	
1. Symptoms result fro	m: 🗌 Inju	ry 🔲 I	llness		2.	Is condition v	vork rel	ated?	Yes	□ No	
3. Diagnosis and comp	lications, if a	ny:						I	CD9-C	M	
4. Date symptoms first	appeared or	date of acc	cident:	_//							
5. Date patient first co	nsulted you fo	or this con	dition:	_ / /	6. 1	Most recent tr	eatment	t date:	_/	/	
7. Describe any other of	disease or con	nplications	affecting p	resent condition:							
8. Date and nature of s											
9. If maternity, give es											
10. Give all treatment d	ates and natur	e of treatn	nent other t	han surgical:							
11. Has patient been ho	spitalized? [☐ Yes	□ No	If yes, dates of	confine	ment: /	/	to		/	
12. Name and address of								10	′	- ' 	
13. Has the patient ever							hen and	describe:			
14. Is patient still under	your care?	☐ Yes	☐ No	If no, give discha	rge date	and degree of	of recov	ery:			
15. Is patient under the	care of anothe	er physicia	n? Ye	s 🗌 No If	yes, pro	vide name an	d addre	ess:			
16. Dates patient was/v				/ /	In any o	occupation:	/	/ t	0	/ /	
17. Patient can return If applicable, des	to work on:	/	_/	Full Time	Part T			rictions			
18. In your opinion, is p If yes, advise nur				on a full or part-ti			□ N	lo			
19. In your opinion, is p	atient a candi	date for re	habilitation	? Yes	No						
20. If patient is diagnos	ed as termina	l, life expe	ctancy is:	\square 6 months or	less [12 month	s or less	s 🗌 Oth	ner		
Physician Signature:		Date:/									
Name (Please Print):		Specialty:									
Address:											
Telephone Number:					Fax N	lumber:					



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.