Group Marketing Services, Inc.

P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611

CONTINUATION OF MEDICAL COVERAGE FOR CONTINUOUS AND TOTAL DISABILITY CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME	2. SOCIAL SECURITY OR CERTIFICATE NUMBER	3. PHONE NUMBER

4. CURRENT ADDRESS	CITY	STATE	ZIP CODE

5. DATE OF BIRTH	6. OCCUPATION (LIST DUTIES OF YOUR OCCUPATION AT THE TIME OF DISBILITY)

7. WHAT WORK DUTIES ARE YOU INCAPABLE OF PERFORM?	8. ARE YOU CAPABLE OF PERFORMING ANY WORK?

9. EMPLOYER'S NAME	10. INITIAL DATE OF INJURY OR SICKNESS

11. LAST DAY WORKED	12. IF INJURY – HOW AND WHERE ACCIDENT OCCURRED

13. **Is this condition due to a work related injury?** ☐Yes ☐No ☐Currently Under Review ☐Unknown
Has this claim been filed under worker's compensation coverage? ☐Yes ☐No

14. **What types of activities are you capable of performing?**

15. **Have you applied for or are you receiving benefits from?**
Social Security: ☐Yes ☐No Worker's Comp: ☐Yes ☐No Group Disability Benefit: ☐Yes ☐No Medicare: ☐Yes ☐No
If "Yes", List name(s) and address of organization or companies paying benefits, weekly or monthly benefits and date benefits commenced:

16. **Do you have other health plan coverage in effect?** ☐Yes ☐No
If Yes; Insurance Company name and effective date:
If No; Are you eligible to enroll in any other health plan coverage? ☐Yes ☐No; If Yes; Insurance Company name:

17. **Have you ever had same or similar sickness or injury?** ☐Yes ☐No; If yes, Indicate Dates:

18. **You Understand the continuation of Major Medical Coverage is employee only coverage?** ☐Yes ☐No

19. **Do you agree to continue to pay the same portion of premium you paid as an active full time employee?** ☐Yes ☐No

20. **Name(s) and address of attending physicians (in last 2 years):**

Name	Address	Treatment Dates

21. **Hospital admission(s) due to disability:**

Hospital Name	Address	Date Entered	Date Discharged

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or waive the breach of any condition of the Policy.

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading Information may be guilty of a criminal act punishable under law. I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

Employee Signature:_____ Date: _____

AUTHORIZATION

I, on behalf of myself or the person named above ("Claimant"), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency, employer, Social Security Administration, Internal Revenue Service, Veterans Administration or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"); its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (except as maybe related directly or indirectly to sexual orientation), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of Human Immuno deficiency Virus (HIV) infection and sexually transmitted diseases.
- Information on the diagnosis & treatment of mental illness & the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand this information maybe released by the Company and/or its reinsurers to their consulting physicians, attorneys, MIB, and to other insurance companies in which the Claimant has policies or to whom claims for benefits have been made or maybe submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Claimant 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 the Claimant's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it maybe subject to re-disclosure and may no longer be protected by the federal rules governing privacy of health information. This authorization is valid for twelve (12) months from the date of 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 at any time by providing written notice to the Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Claimant to obtain treatment. I further understand that if I refuse to sign this authorization, Company may not be able to make any benefit payments.

I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Insured or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Insured:_____

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CONTINUATION OF MEDICAL COVERAGE FOR CONTINUOUS AND TOTAL DISABILITY CLAIM FORM

TO BE COMPLETED BY EMPLOYER

1. EMPLOYEE'S NAME	2. SOCIAL SECURITY OR CERTIFICATE NUMBER	3. FULL TIME HIRE DATE

4. EMPLOYER'S NAME	5. OCCUPATION AT TIME OF DISABILITY	6. REASON FOR STOPPING WORK

7. RETURN TO WORK ON:	8. BASIC MONTHLY EARNINGS: $ ☐Hourly ☐Salaried	9. WAS EMPLOYEE COVERED FOR MEDICAL BENEFITS ON LAST DAY WORKED? ☐YES ☐NO	10. LAST DAY WORKED

11. EMPLOYEE'S DUTIES:

12. EMPLOYEE CAN PERFORM JOB DUTIES: ☐ WITH NO RESTRICATION ☐ WITH RESTRICTIONS ☐ CANNOT PERFORM

EXPLAIN RESTRICTIONS:

13. WHAT JOB DUTIES CAN THIS EMPLOYEE NOT PERFORM DUE TO THEIR CONDITION?

14. DID EMPLOYEE CEASE WORK BECAUSE OF DISABILITY? ☐ YES OR ☐ NO

15. DOES EMPLOYEE'S RESPONSIBILITIES INCLUDE HEAVY LIFTING OR HEAVY MANUAL LABOR? ☐ YES OR ☐ NO

16. IS THERE A POSITION AVAILABLE FOR THIS EMPLOYEE IF THEY CAN RETURN TO WORK UNDER RESTRICTED OR LIGHT DUTY? ☐ YES OR ☐ NO

17. IS THE DISABLING CONDITION DUE TO, OR RELATED TO, THE EMPLOYEE'S EMPLOYMENT? ☐ YES OR ☐ NO

18. WAS A WORKER'S COMPENSATION CLAIM FILED FOR THIS DISABILITY: ☐ YES OR ☐ NO; IF YES, ATTACH WORKERS COMP CARRIERS DETERMINATION

19. TOTAL DISABILITY DATES: FROM: TO:

20. IS EMPLOYER LARGE ENOUGH TO OFFER:..... FMLA EXTENSION: ☐YES ☐NO COBRA EXTENSION: ☐YES ☐NO

IF YES, HAS THIS EMPLOYEE BEEN OFFERED:..... FMLA EXTENSION: ☐YES ☐NO COBRA EXTENSION: ☐YES ☐NO

IF YES, HAS THIS EMPLOYEE ELECTED: ..... FMLA EXTENSION: ☐YES ☐NO COBRA EXTENSION: ☐YES ☐NO

21. WILL EMPLOYER CONTINUE TO PAY THE SAME PORTION OF PREMIUM THAT THEY PAID WHILE THIS EMPLOYEE WAS FULL TIME AND ACTIVELY AT WORK? ☐ YES ☐ NO

PORTION OF PREMIUM EMPLOYEE PAYS WHILE OFF WORK:$_____ ☐WEEKLY ☐BI-WEEKLY ☐MONTHLY ☐OTHER;_____

22. YOU UNDERSTAND THE CONTINUATION OF COVERAGE IS FOR EMPLOYEE ONLY COVERAGE? ☐Yes ☐No

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or waive the breach of any condition of the Policy.

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading Information may be guilty of a criminal act punishable under law. I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

NAME:_____ TITLE:_____

(PRINT)

SIGNATURE:_____ DATE:_____

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CONTINUATION OF MEDICAL COVERAGE FOR CONTINUOUS AND TOTAL DISABILITY CLAIM FORM

TO BE COMPLETED BY PHYSICIAN

1. PATIENT'S NAME: | **2. PATIENT'S BIRTH DATE:**

3. HISTORY

(a) When did symptoms first appear or accident occur?..... Month_____ Day_____ Year_____

(b) Date patient ceased work because of disability ..... Month_____ Day_____ Year_____

(c) Has patient ever had same or similar condition?..... ☐ YES ☐ NO

(d) Is condition due to injury or sickness arising from patient's employment? ☐ YES ☐ NO ☐ UNKNOWN

4. DIAGNOSIS

(a) Date of last examination ..... Month_____ Day_____ Year_____

(b) Diagnosis (including any complications): ....._____

(c) Nature of condition: ..... ☐ SICKNESS ☐ INJURY ☐ OTHER; EXPLAIN

(d) Subjective symptoms ....._____

(e) Objective findings (Including current X-rays, EKG's, Laboratory Data and any clinical findings)_____

_____

5. DATES OF TREATMENT

(a) Date of first visit..... Month_____ Day_____ Year_____

(b) Date of last visit ..... Month_____ Day_____ Year_____

(c) Frequency ..... ☐ WEEKLY ☐ MONTHLY ☐ OTHER (SPECIFY)

(d) Is patient still under your care for this condition?..... ☐ YES ☐ NO

6. NATURE OF TREATMENT (Including surgery and medications prescribed, if any)

7. PROGRESS

(a) Has patient..... ☐ RECOVERED ☐ IMPROVED ☐ UNCHANGED ☐ UNCHANGED

(b) Is patient ..... ☐ AMBULATORY ☐ HOUSE CONFINED ☐ BED CONFINED ☐ HOSPITAL CONFINED

(c) Has patient been hospital confined ..... ☐ YES ☐ NO

8. CARDIAC (If applicable)

(a) Functional Capacity ..... ☐ CLASS 1 (No limitation) ☐ CLASS 2 (Slight limitation) ☐ CLASS 3 (Marked limitation) ☐ CLASS 4 (Complete limitation)

Blood Pressure (last visit) ..... (American Heart Ass'n)_____ (Systolic/Diastotic)

9. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Tides)

☐ CLASS 1 – No limitation of functional capacity: capable of heavy work* No restriction. (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 minimum (sedentary*) activity. (75 – 100%)

Remarks:

10. MENTAL / NERVOUS IMPAIRMENT (IF APPLICABLE)

(a) Define "Strees" as it applies to this claimant:

(b) What stress and problems in interpersonal relations has claimant had on job?

☐ 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:

(c) Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?..... ☐ YES ☐ NO

11. PROGNOSIS

	PATIENT'S JOB		ANY OTHER WORK	
(a) Is patient now totally disabled?.....	☐ YES	☐ NO	☐ YES	☐ NO
(b) What duties of patient's job is he/she incapable of performing?				
(c) Do you expect a fundamental of marked change in the future?.....	☐ YES	☐ NO	☐ YES	☐ NO
(1) If Yes, when will patient recover sufficiently to perform duties?..... _____ Mo. Day Year	☐ 1 mo. ☐ 3-6 mos ☐ 1-3 mos. ☐ Never		_____ Mo. Day Year ☐ 1 mo. ☐ 3-6 mos. ☐ 1-3 mos. ☐ Never	
(2) If No, please explain				

12. REHABILITATION

	PATIENT'S JOB		ANY OTHER WORK	
(a) Is patient a suitable candidate for further rehabilitation services? (i.e. cardio pulmonary program, speech therapy, etc.)	☐ YES	☐ NO	☐ YES	☐ NO
(b) Can present job be modified to allow for handling with impairment?..	☐ YES	☐ NO		
(c) When could trial employment commence? .. _____ Mo. Day Year	☐ Full Time	☐ Part Time	_____ Mo. Day Year ☐ Full Time	☐ Part Time

DATE: SIGNED:

INDIVIDUAL PRACTITIONER'S SS/TIN/NPI #: DEGREE:

( )

PHONE NUMBER (CITY / STATE / ZIP)