Boston Mutual Life Insurance Company
Group Disability
Claim Filing Instructions

IMPORTANT: All portions of this claim form must be completed ***after*** disability begins to avoid undue delay in processing claimant's request for benefits. If you have any questions when completing this form, please call our:

Toll Free Number - (800) 320-4445

1. Complete "Employee - Initial Disability Benefits Claim Form" in full.
2. Have treating physician complete the "Physician - Initial Disability Claim Form" and return to you.
3. Have Employer complete the "Employer - Initial Claim Form" and return to you.
4. Submit *all* completed forms to the address below or you may fax *all* completed forms to our:

Toll Free Fax Number - (888) 594-5729.

Mail To:
Boston Mutual Life Insurance Company
Benefits Administration
P.O. Box 268956
Oklahoma City, OK 73126-8956

Mail to: Boston Mutual Life Insurance Company
Benefits Administration
P.O. Box 268956
Oklahoma City, OK 73126-8956
Toll Free Phone # 1-800-320-4445
Toll Free Fax # 1-888-594-5729

EMPLOYER – INITIAL CLAIM FORM

Employee Name:	Social Security Number:
Occupation:	Hire Date:

STATUS OF EMPLOYMENT: Full Time: ❏ Part Time: ❏ Days per week: ________ Hours per day: _________

If employee's status has changed, please check the appropriate box and provide change date below:

Lay Off: ❏ Leave of Absence: ❏ Terminated: ❏ Retired: ❏

PREMIUMS:

Are the employee's disability premium contributions deducted pre-tax ❏ or post-tax ❏?

What percentage of the disability premiums do you pay?_________%

Are Social Security taxes withheld from employee's pay check? Yes ❏ No ❏

Date that last disability premiums deducted from payroll:___________ Amount deducted: $__________

SALARY AT TIME OF DISABILITY:

Hourly: $_________ Weekly: $__________ Monthly: $__________

Annually: $__________________ (W-2, previous calendar year) $______________________ (Year-to-date, current calendar year)

Date last worked?______________________

Has employee returned to work? Yes ❏ No ❏ Return date: ________________ Full Time ❏ Part Time ❏

Is the employee receiving or eligible to receive any of the following?

	Yes	No	Amount	Wk	Mo	Company Name and Phone Number	Dates Benefits Begin	End
Other Group Disability	❏	❏	$	❏	❏			
Salary Continuation	❏	❏	$	❏	❏			
Sick Leave	❏	❏	$	❏	❏			
PTO/PPT	❏	❏	$	❏	❏			
Other (Bonus, etc.)	❏	❏	$	❏	❏			
Retirement/Pension	❏	❏	$	❏	❏			

Is disability the result of work related injury/illness? Yes ❏ No ❏

If yes, has a Workers' Compensation claim been filed? Yes ❏ No ❏

Please provide name and phone number of Workers' Compensation carrier:

Employer Name:	Office Phone Number:	Fax Phone Number:	
Street Address:	City:	State:	Zip Code:
Form completed by: (please print)		Title:	
Signature:		Date:	

This documents that the above statements are true and complete to the best of my knowledge.

BD-1321-0706

Mail to: **Boston Mutual Life Insurance Company**
Benefits Administration
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Oklahoma City, OK 73126-8956
Toll Free Phone # 1-800-320-4445
Toll Free Fax # 1-888-594-5729

EMPLOYEE - INITIAL DISABILITY CLAIM FORM

WARNING: **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 may be guilty of insurance fraud and subject to criminal and civil penalties.**

Name:	Social Security Number:	Date of Birth:

Complete Mailing Address:	Complete Resident Address:	Telephone Number:

Do you have dependents under age 18? Yes ❑ No ❑ If yes, please list dependent names and birth dates below:

1) Please list medical condition or injury causing disability:

2) If disability is the result of an accident, please explain where, when, and how accident happened:

3) Is your disability the result of your employment? Yes ❑ No ❑ If yes, please submit copy of Workers' Compensation award or denial letter.

4) Please list all dates of medical treatment pertaining to current disability:

5) Have you ever had or been treated for same or similar condition? Yes ❑ No ❑ If yes, please explain:

6) Please list name and phone number of treating physician(s):

7) Date Last Worked:

Date Returned to Work:

8) If you *have not* returned to work, what is the anticipated return date?

❑ Full Time: ______________________

❑ Part Time:______________________

9) If your request for benefits is approved, do you want Federal Taxes withheld from each benefit check?
Yes ❑ No ❑

If yes, please indicate dollar amount below:
(Minimum amount required is $87 per month.) $________________

10) Please identify other income sources and amounts of income which you are receiving or may be entitled to receive during this disability:

Source	Yes	No	Amount	Source	Yes	No	Amount
Social Security - Disability ❑ Retirement ❑	Yes ❑	No ❑	$__________	V.A. Benefits	Yes ❑	No ❑	$___________
Dependent Social Security	Yes ❑	No ❑	$__________	Sick Leave or Wage Continuation	Yes ❑	No ❑	$___________
State Disability	Yes ❑	No ❑	$__________	Retirement (normal, early, or disability)	Yes ❑	No ❑	$___________
Other Group Disability Coverage	Yes ❑	No ❑	$__________				

Include a copy of your award or denial letter from any source that you have received.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing Boston Mutual Life Insurance Company (BMLIC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in the caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial of benefits. I understand that I may revoke this authorization at any time by writing to Boston Mutual Life Insurance Company, Benefits Administration, P.O. Box 268956, Oklahoma City, Oklahoma 73126-8956 or calling toll free 1-800-320-4445. I understand that my right to revoke this authorization is limited to the extent that BMLIC has taken action in reliance on the authorization; or, the law provides BMLIC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original. I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations.

For health insurance coverage, this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. For Arizona residents, release of HIV/AIDS released information can only be disclosed for a period not to exceed 180 days from the date shown below.

Signature :____ Print Insured's/Patient Name: ____________________________________ Date:______________

Please retain a copy for your personal records, or you may request a copy from our company.

FAILURE TO SIGN & DATE FORM WILL DELAY BENEFITS

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Benefits Administration
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Oklahoma City, OK 73126-8956
Toll Free Phone # 1-800-320-4445
Toll Free Fax # 1-888-594-5729

PHYSICIAN - INITIAL DISABILITY CLAIM FORM

Patient's Name:	Social Security Number:	Date of Birth:

Diagnosis: Please list diagnosis resulting in patient's *temporary* total disability (including complications)

Diagnosis: ____________________ ICD9 Code: ____________________

Diagnosis: ____________________ ICD9 Code: ____________________

Is disability the direct result of patient's employment? Yes ❑ No ❑

Is disability the result of a pregnancy? Yes ❑ No ❑ If yes, date pregnancy was diagnosed:

Delivery date: (if delivered) Expected delivery date: (if not delivered)

History: Was the patient referred to you? Yes ❑ No ❑ Unknown❑ If yes, please provide name and phone number of referring physician:

Date symptoms first appeared or accident happened?	Date patient first consulted you for this condition?

Are you aware if this patient has ever had the same or similar condition? Yes ❑ No ❑ If yes, please provide explanation including first date of onset.

Treatment: Is patient still under your care? Yes ❑ No ❑ If yes, date of next appointment: ____________________

List all treatment dates:____________________

Please describe treatment plan: ____________________

If patient is no longer under your care, please provide name and phone number of current physician: Unknown ❑

Has patient been confined to a hospital? Yes ❑ No ❑ Admitted: ____________ Discharged: ____________
Hospital Name: Phone Number:

If surgery is/was necessary, please list procedure(s):

Date scheduled: Date performed:

Prognosis: **Please list date(s) of temporary total disability (unable to work) From:** ____________ **Through:** ____________

If patient is currently totally disabled, please indicate the anticipated length of disability by checking the appropriate box below:

Months: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 or Permanently Disabled ❑ or Other ❑ ____________

Impairment: List functional limitations/restrictions that render your patient *temporarily* totally disabled:

Attending Physician's Name: (please print)	Degree:	Specialty:
Street Address:	City:	State/Zip Code:
Office Phone Number:	Fax Phone Number:	Federal Tax ID Number:
Form completed by:	Title:	
Signature of Physician:		Date:

Attention Physician: This form documents your verification that the above named individual is totally disabled from their occupation. You will be asked periodically for updates related to the individual's disability and treatment plan.

BD-1321-0706