Combined Life Insurance Company of New York

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-951-6206 • Fax 312-351-6930

Continuation of Disability Claim Form

CLAIMANT STATEMENT - PLEASE COMPLETE AND RETURN

FIRST NAME | LAST NAME | M.I.

CLAIM NUMBER | POLICY/CERTIFICATE NUMBER(S)

PRIMARY PHONE

MAILING ADDRESS

CITY | STATE | ZIP

E-MAIL ADDRESS

PLEASE DESCRIBE ANY COMPLICATIONS OF INJURY OR ILLNESS SINCE LAST REPORT.

LIST MEDICAL TREATMENTS RECEIVED SINCE LAST REPORT

DOCTOR'S NAME | TREATMENT DATES: FROM (MM DD YYYY) THROUGH (MM DD YYYY)

ADDRESS

CITY | STATE | ZIP

DOCTOR'S NAME | TREATMENT DATES: FROM (MM DD YYYY) THROUGH (MM DD YYYY)

ADDRESS

CITY | STATE | ZIP

HOSPITAL CONFINEMENT SINCE LAST REPORT

HOSPITAL NAME

ADDRESS

CITY | STATE | ZIP | ADMISSION DATE (MM DD YYYY) | DISCHARGE DATE (MM DD YYYY)

HOSPITAL NAME

ADDRESS

CITY | STATE | ZIP | ADMISSION DATE (MM DD YYYY) | DISCHARGE DATE (MM DD YYYY)

HAVE YOU RETURNED TO WORK OR YOUR USUAL DAILY ACTIVITIES?

YES [X] NO [X] IF YES, PLEASE INDICATE THE ACTUAL DATE YOU RETURNED TO WORK OR YOUR USUAL DAILY ACTIVITIES.

DATE (MM DD YYYY)

IF YOU RETURNED TO WORK, PLEASE INDICATE ONE OF THE FOLLOWING: FULL TIME NO RESTRICTIONS [X] FULL TIME WITH RESTRICTIONS [X] PART TIME [X]

IF YOU RETURNED TO WORK WITH RESTRICTIONS OR PART TIME, PLEASE INDICATE WORK RESTRICTIONS ON YOUR RETURN TO WORK DATE.

PLEASE INDICATE THE DATE THESE WORK RESTRICTIONS WILL BE APPLICABLE THROUGH. (MM DD YYYY)

HAVE YOU FILED FOR A CLAIM UNDER ANY OF THE FOLLOWING BENEFITS LISTED BELOW?

WORKERS' COMPENSATION ACT YES [X] NO [X]

SOCIAL SECURITY ACT YES [X] NO [X]

STATE DISABILITY YES [X] NO [X]

IF YES, TO ANY OF THE ABOVE, PLEASE SUBMIT A COPY OF THE AWARD OR DENIAL LETTER IF RECEIVED UNLESS ALREADY PROVIDED.

DATE (MM DD YYYY) | SIGNATURE

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME | LAST NAME | M.I. | AGE

ADDRESS

CITY | STATE | ZIP

NATURE AND ORIGIN OF: [X] SICKNESS [X] INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? MM DD YYYY

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? MM DD YYYY

IF SICKNESS, WHEN WAS CONDITION FIRST DIAGNOSED? MM DD YYYY

INDICATE THE DATE AND TYPE OF DIAGNOSTIC TEST USED TO DIAGNOSE CURRENT CONDITION. IF MORE TESTS WERE PERFORMED, PLEASE INCLUDE SUPPORTING DOCUMENTATION.

MM DD YYYY

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES [X] NO [X]

(IF "YES", STATE WHEN AND DESCRIBE.) MM DD YYYY

HOW DID CONDITION ORIGINATE?

DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)

DATE MM DD YYYY

PROCEDURE

NAME OF FACILITY

OPEN OR CLOSED REDUCTION

OPEN [X] CLOSED [X]

GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.

OFFICE

DATE MM DD YYYY

MM DD YYYY

MM DD YYYY

NATURE OF TREATMENT(S)

NAME OF FACILITY

EMERGENCY ROOM (ER)

DATE MM DD YYYY

NATURE OF TREATMENT

NAME OF FACILITY

URGENT CARE FACILITY

DATE MM DD YYYY

NATURE OF TREATMENT

NAME OF FACILITY

IS THE PATIENT STILL UNDER YOUR CARE? YES [X] NO [X]

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?

FROM MM DD YYYY THROUGH MM DD YYYY

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?

FROM MM DD YYYY THROUGH MM DD YYYY

PLEASE STATE RESTRICTIONS PLACED ON PATIENT FOR ANY DISABILITY THAT HAS BEEN INDICATED.

IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? YES [X] NO [X] (IF "YES", GIVE RETURN TO WORK DATE.)

RETURN TO WORK DATE MM DD YYYY

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.

HOSPITAL NAME

ADMISSION DATE MM DD YYYY

DISCHARGE DATE MM DD YYYY

ADDRESS

CITY | STATE | ZIP

PHYSICIAN'S NAME | DEGREE | SIGNATURE

PHONE NUMBER | FAX NUMBER | DATE MM DD YYYY | STAMP

ADDRESS

CITY | STATE | ZIP

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

INDIVIDUAL PRACTITIONER'S S.S. NO. | ALL OTHERS - EMPLOYER I.D. NO.

EMPLOYER'S STATEMENT

IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION C – EMPLOYER'S STATEMENT. PLEASE NOTE: IF THE INSURED IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE THIS SECTION.

EMPLOYEE'S FIRST NAME	LAST NAME	M.I.

CITY	STATE	ZIP

PHONE NUMBER	BIRTH DATE	CLAIM NUMBER (IF AVAILABLE)
	MM DD YYYY	

DATE LAST WORKED	DATE RETURNED TO WORK		MONTHLY EARNINGS
MM DD YYYY	MM DD YYYY	FULL TIME [X] PART TIME [X]	$,

POLICY NUMBER(S)

EMPLOYEE'S OCCUPATION	DESCRIPTION OF OCCUPATION'S PRIMARY DUTIES

WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? YES [X] NO [X] **PAID?** YES [X] NO [X]

IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.

NAME

ADDRESS

CITY	STATE	ZIP

PHONE NUMBER

PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)

SITTING HH MM **PER DAY** **WALKING** HH MM **PER DAY** **CLIMBING STAIRS/LADDERS** HH MM **PER DAY** **DRIVING** HH MM **PER DAY**

LIFTING: [X] **LESS THAN 15LBS** [X] **15 TO 45LBS** [X] **MORE THAN 45LBS** **STOOPING/BENDING:** [X] **NONE** [X] **SELDOM** [X] **FREQUENT**

TOTAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES?		PARTIAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES?	
FROM	**THROUGH**	**FROM**	**THROUGH**
MM DD YYYY	MM DD YYYY	MM DD YYYY	MM DD YYYY

DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75% OR MORE OF HIS PRE-DISABILITY INCOME? YES [X] NO [X] **IF NO, WHAT PERCENTAGE?** _____ %

DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)

EMPLOYER CONTACT NAME	CONTACT'S POSITION	DATE
		MM DD YYYY

SIGNATURE	PHONE NUMBER	FAX NUMBER

REQUIRED SIGNATURE OF CLAIMANT

FRAUD WARNING

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.

X_____ _____ _____

CLAIMANT'S SIGNATURE | DATE | PLEASE PRINT NAME

I signed on behalf of the claimant, as _____ (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your employer regarding reporting requirements.

You must sign and date this claim form on the signature line provided on this page. If you do not sign this claim form, we cannot accept your claim submission.

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CONSENT TO ELECTRONIC TRANSACTIONS, PAYMENTS AND SIGNATURE

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Life Insurance Company of New York ("Combined") of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at https://my.combinedinsurance.com or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-800-951-6206, Monday through Friday between 7:30 am and 6:00 pm CST or go to www.combinedinsurance.com/us-en/contact-us to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

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You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

Print Name

_____

Signature

E-mail Address

_____

Date