

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 Telephone 1-800-488-0603 • Fax 312-351-7080

# **Continuation of Disability Claim Form**

	NT STAT	TEMENT -				ETE /	AND F	RETU	RN									
FIRST NAME			LAST	NAM	IE													M.I.
CLAIM NUMBER			POLIC	CY/CE	ERTIF	ICATE	NUN	IBER(	(S)									
PRIMARY PHONE																		
MAILING ADDRESS																		
											0747							
CITY											STATE		ZIP					
E-MAIL ADDRESS																		
PLEASE DESCRIBE ANY COMPLICATIONS OF INJURY OR ILLNESS SINCE	LAST R	EPORT.																
LIST MEDICAL TREATMENTS RECEIVED SINCE LAST REPORT																		
DOCTOR'S NAME		TREATMI DATES:	ENT	FROI	M (MN	//DD/\	YYY)						THRO	JGH (M	M/DD/YY	YY)		
		DATES.				/	/							/	/			
ADDRESS																		
CITY												:	STATE		ZIP			
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		DATES:						1						/	/			
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HOSPITAL NAME																		
ADDRESS																		
CITY	ATE	ZIP			A	DMISS	ION [	DATE	(MM/D	D/YY	(YY)		DIS	CHAR	SE DATE	(MM/D	D/YYYY	)
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HOSPITAL NAME																		
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ADDRESS																		
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CITY STA	ATE	ZIP			AI	OMISS	ION E	DATE	(MM/D	D/YY	YY)		DIS	CHARG	SE DATE	(MM/DI	D/YYYY	)
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HAVE VOLUBETURNED TO MORK OR VOLUBURIAL DAILY ACTIVITIES?											DAT	- /AAB	MDD/	,				
HAVE YOU RETURNED TO WORK OR YOUR USUAL DAILY ACTIVITIES?									OT!! !!			E (IVIII	//DD/Y	/ /				
YES NO IF YES, PLEASE INDICATE THE ACTUAL DATE YO	OU RETU	IRNED TO	WOR	KOR	YOUR	R USU.	AL DA	AILY A	CTIVI	TIES.			/	/		$\perp$		
IF YOU RETURNED TO WORK, PLEASE INDICATE ONE OF THE FOLLOWING	G: FU	ILL TIME I	NO RES	STRIC	CTION	S	F	-ULL	TIME V	VITH	REST	RICTI	ONS	F	PART TIM	Æ		
IF YOU RETURNED TO WORK WITH RESTRICTIONS OR PART TIME, PLEASE	E INDICA	ATE WOR	K RES	TRICT	TIONS	ON Y	OUR	RETŪ	RN TO	wo	RK DA	TE.						
PLEASE INDICATE THE DATE THESE WORK RESTRICTIONS WILL BE APPLI	ICABLF	THROUG	H. (MM	I/DD/\	YYYY			/		/								
								J <b>ʻ</b>		•			_					
HAVE YOU FILED FOR A CLAIM UNDER ANY OF THE FOLLOWING BENEFIT WORKERS' COMPENSATION SOCIAL SECUR		ED BELO	w?			STATE	<u> </u>								ANY O			PLEASE OR
ACT YES NO ACT	YE	s	NO			DISAE		YE	s		NO		DE	NIAL LI	ETTER II	RECE		
DATE (MM/DD/YYYY) SIGNATURE																		

PATIENT'S FIRST NAM	E		A'		NG PHY LAST N	SICIAN'S IAME	STATEN	MENT									M.I.	AGE	AGE				
ADDRESS																			] [			_	
CITY													STA	TE	ZIP				_			_	
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	INJU	IRY																					
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(MM/DD/YYYY)				(MM/DD	/YYYY)							(N	IM/DD/Y	YYY)									
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INDICATE THE DATE A (MM/DD/YYYY)	ND TYPE OF DIA	AGNOSTIC TE	STUSED	TO DIAGNO	SE CURR	ENT CO	NDITIO	N. IF MOF	RE TEST	SWER	E PERF	ORME	D, PLEA	SE INC	LUDE	SUPF	PORTI	NG D	COM	ENTAT	ION.		
/ /																							
HAS PATIENT EVER HA	AD SAME		(IF '	'YES", STAT	E WHEN	AND DE	SCRIBI	E.) (MM/DI	D/YYYY)													_	
OR SIMILAR CONDITIO		NO		/	/																		
HOW DID CONDITION	ORIGINATE?							DESCR	IBE AN	YOTHE	R DISE	ASE O	R INFIR	MITY AF	FECTI	ING P	PRESE	NT C	DNDIT	ION.			
NATURE OF SURGICA	OR OBSTETRI	CAL PROCE	URF(S) IF	ANY (DES	CRIBE EL	II I Y)																_	
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	/	/		NAME OF																			
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(2.1.)	/	/		NAME OF	. –																		
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FACILITY	/	/		NAME OF																			
IS THE PATIENT STILL	HOW LONG WA	S OR WILL P	ATIENT BE	FACILITY	USI Y TO	TALLY	DISABI	FD	нои	V I ONG	WAS C	OR WII	I PATIF	NT BE I	PARTIA	ALLY	DISAF	BLED?	<del></del>			_	
UNDER YOUR CARE?									HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?														
	FROM (MM/DD/	YYYY)		THRO	UGH (MN	I/DD/YY`	YY)		FRO	M (MM	/DD/YYY	YY)			THROUGH (MM/DD/YYYY)								
YES NO		//			/	/				/		/					_/_		_/				
PLEASE STATE RESTR	RICTIONS PLACE	ED ON PATIEN	NT FOR AN	IY DISABILI	TY THAT	HAS BEI	EN INDI	CATED.															
IF PATIENT DISABLED	ON DATE YOU	COMPLETE T	HIS FORM,	, IS THERE A	RETUR	N TO WC	ORK DA	TE?	RETU	/YYYY)								_					
YES NO	(IF "YES", G	IVE RETURN	TO WORK	DATE.)						1		1											
IF HOSPITALIZED, GIV	E NAME AND AD	DRESS OF H	IOSPITAL A	AND DATES	OF CONF	INEMEN	NT.		ADM	ISSION	DATE (	MM/DE	D/YYYY)		DISCHARGE DATE (MM/DD/YYYY)								
HOSPITAL NAME										/		/					/		/				
ADDRESS																						_	
CITY													STA	TE	ZIP							_	
PHYSICIAN'S NAME						DEGRE	E			SIGN	IATURE											_	
PHONE NUMBER			FAX NUM	BER				DA	TE (MM	/DD/YY	YY)			S	TAMP								
1000565											/												
ADDRESS																							
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INDIVIDUAL PRACTITI	ONER'S S.S. NO							ALL OTHE	RS - EN	IPLOY	ER I.D. I	NO.										1	
							- 1																

	EMPLOYER'S	STATEMENT	
IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER IS A STUDENT. THE SCHOOL PRINCIPAL SHOULD COMPLETE TH		Y BY COMPLETING SECTION C - E	MPLOYER'S STATEMENT. PLEASE NOTE: IF THE INSURED
EMPLOYEE'S FIRST NAME	LAST	NAME	M.I.
Emileo Teles of Inchine	LAGIT	NAME	
CITY			STATE ZIP
			OTAL ELI
PHONE NUMBER	BIRTH DATE (MM/DD/YYYY)		CLAIM NUMBER (IF AVAILABLE)
DATE LAST WORKED (MM/DD/YYYY) DATE RETURNS	ED TO WORK (MM/DD/YYYY)		MONTHLY EARNINGS
		FULL TIME PART TIME	\$ ,
			Ψ , , , , , , , , , , , , , , , , , , ,
POLICY NUMBER(S)			
EMPLOYEE'S OCCUPATION		DESCRIPTION OF OCCUPATION	'S PRIMARY DUTIES
WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY?	YES NO PAI	D? YES NO	
IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER	R OF COMPENSATION CARRIE	R. ALSO, SEND REPORT OF INITIAL	L INJURY.
NAME			
12222			
ADDRESS			
CITY			STATE ZIP
PHONE NUMBER			
PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)			
SITTING PER DAY WALKING H H H	M M		PER DAY DRIVING PER DAY  M M H H M M
LIFTING: LESS THAN 15LBS 15 TO 45LBS	MORE THAN 45LBS	STOOPING/BENDING:	: NONE SELDOM FREQUENT
TOTAL DISABILITY:		PARTIAL DISABILITY:	
BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY	JOB DUTIES?		E EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES?
FROM (MM/DD/YYYY) THROUGH (MM.	/DD/YYYY)	FROM (MM/DD/YYYY)	THROUGH (MM/DD/YYYY)
		/	
	, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75%	OR MORE OF HIS PRE-DISABIL	ITY INCOME? YES NO	IF NO, WHAT PERCENTAGE? %
DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILIT	<b>'Y</b> )		
EMPLOYER CONTACT NAME	CONTACT'S POSITION		DATE (MM/DD/YYYY)
	CONTROL OF CONTON		
SIGNATURE	PHONE	NUMBER	FAX NUMBER

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#### FRAUD NOTIFICATIONS

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

**ALABAMA**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**ALASKA:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**ARIZONA:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**ARKANSAS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CALIFORNIA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

**COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**DELAWARE:** 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 is guilty of a felony.

**DISTRICT OF COLUMBIA:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the Applicant.

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

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA:** A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MARYLAND:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

**NEW MEXICO:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

#### FRAUD NOTIFICATIONS CONTINUED

**NEW YORK:** 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.

**OHIO:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PENNSYLVANIA:** 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.

**PUERTO RICO:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) and not more than ten thousand (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**RHODE ISLAND:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**TEXAS:** 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.

**VIRGINIA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

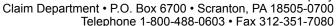
**WEST VIRGINIA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ALL OTHER STATES:** Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.

REQUIRED SIGNATURE OF CLAIMANT		
By making claim to these proceeds, I declare that all best of my knowledge and belief. I have read the appreserves the right to require or obtain further informat	plicable fraud notification stat	ement. I also understand the Company
CLAIMANT'S SIGNATURE	DATE	PLEASE PRINT NAME
I signed on behalf of the claimant, as Power of Attorney, Guardian or Conservator, please	attach a copy of the docume	(relationship). If you are the nt 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.





## 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 Insurance Company of America ("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 <a href="https://my.combinedinsurance.com">https://my.combinedinsurance.com</a> 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 1-800-488-0603, Monday through Friday between 7:30 am and 6:00 pm CST or go to <a href="https://www.combinedinsurance.com/us-en/PFP/contact-us">www.combinedinsurance.com/us-en/PFP/contact-us</a> 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.

## **Combined Insurance Company of America**

A Chubb Company

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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

future reference.																
Print Name																
Fillit Name																
Signature						 _										
E-mail Address						_										
Date																

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