



Worksite Solutions Division Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 Telephone 1-800-544-9382 • Fax 312-351-6930

Continuation of Disability Claim Form

FIRST NAME CLAIMANT ST	ATEMENT -		SE CO		TE AN	D RETU	JRN									M.I	 -
				_													
CLAIM NUMBER		POLI	CY/CE	RTIFIC	ATE N	UMBER	R(S)										_
PRIMARY PHONE																	
MAILING ADDRESS																	
CITY								S	TATE	Z	IP						
E-MAIL ADDRESS																	
PLEASE DESCRIBE ANY COMPLICATIONS OF INJURY OR ILLNESS SINCE LAST	REPORT.																
LIST MEDICAL TREATMENTS RECEIVED SINCE LAST REPORT																	
DOCTOR'S NAME	TREATMI DATES:	ENT	FROM	I (MM/I /	OD/YYY	M) /				THI	ROUGI	(MM/I	DD/YYY /	Y)			
ADDRESS																	
CITY										STA	ATE		ZIP				
										"							
DOCTOR'S NAME	TREATME DATES:	ENT	FROM	1 (MM/I	DD/YY	YY) /				THI	ROUGI	i (MM/i	DD/YYY	Y)			
ADDRESS				,									,				
CITY										STA	ATE		ZIP				
HOSPITAL CONFINEMENT SINCE LAST REPORT																	
HOSPITAL NAME																	
ADDRESS																	
··																	
CITY STATE	ZIP			ADN	IISSIO	N DATI	(MM/D	D/YYY	(Y)		DISCH	ARGE	DATE (MM/DD	YYYY)	_
					1		/					/		/			
HOSPITAL NAME	•																
ADDRESS																	
CITY STATE	ZIP			ADN	IISSIO /	N DATE	(MM/D	D/YYY	Υ)		DISCH	ARGE /	DATE (I	MM/DD/	YYYY))	
HAVE YOU RETURNED TO WORK OR YOUR USUAL DAILY ACTIVITIES?									DATE	(MM/D	D/YYY	Y)					_
YES NO IF YES, PLEASE INDICATE THE ACTUAL DATE YOU RET	TURNED TO	WOR	K OR Y	OUR (JSUAL	DAILY	ACTIVIT	TIES.		1		1					
IF YOU RETURNED TO WORK, PLEASE INDICATE ONE OF THE FOLLOWING:	ULL TIME N	NO RE	STRIC	TIONS		FULL	. TIME V	VITH R	RESTRI	CTION	s	PAF	RT TIME				
IF YOU RETURNED TO WORK WITH RESTRICTIONS OR PART TIME, PLEASE INDI	CATE WOR	K RES	TRICT	IONS C	N YOU	JR RET	URN TO	WOR	K DATI	Ε.							
PLEASE INDICATE THE DATE THESE WORK RESTRICTIONS WILL BE APPLICABL	E THROUG	iH. (MN	//DD/Y	YYY)		/		/									
HAVE YOU FILED FOR A CLAIM UNDER ANY OF THE FOLLOWING BENEFITS LIS WORKERS' COMPENSATION ACT YES NO ACT Y	TED BELO	W? NO			ATE SABIL	ITY Y	ES	N	10		SUBM DENIA	IT A CO	NY OF TOPY OF	THE A	WARD	OR	
DATE (MM/DD/YYYY) SIGNATURE													-				

PATIENT'S FIRST NAME		ATTENDING PHY		MENT		M.I. AGE
FATIENT STINST NAME		LASTIN	AWIL			Mil. AGE
ADDRESS						
CITY				5	STATE ZIP	
	DIAGNOSIS (DESCRIBE CO	MPLICATIONS, IF ANY)				
NATURE AND ORIGIN OF:						
INJURY						
WHEN DID SYMPTOMS FIRST APPEAR OR ACCI (MM/DD/YYYY)	DENT HAPPEN? WHEN D	ID PATIENT FIRST CON	SULT YOU FOR		NESS, WHEN WAS CONI	DITION FIRST DIAGNOSED?
((IIIIII BB)	/ /		(MINUSE	/ / /	
INDICATE THE DATE AND TYPE OF DIAGNOSTIC	TEST USED TO DIAGNOS	E CURRENT CONDITIO	N. IF MORE TES	TS WERE PERFORMED, PL	EASE INCLUDE SUPPOR	RTING DOCUMENTATION.
(MM/DD/YYYY)						
/ /	//E "VEQ" STATE	WHEN AND DESCRIBE	= \ /MM/DD/VVVV	^		
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES N	(IF "YES", STATE	/ / DESCRIBE	=.) (IVIIVI/DD/	1)		
HOW DID CONDITION ORIGINATE?		,	DESCRIBE AN	NY OTHER DISEASE OR INF	IRMITY AFFECTING PRE	SENT CONDITION.
NATURE OF SURGICAL OR OBSTETRICAL PROD DATE (MM/DD/YYYY) PRO	CEDURE(S), IF ANY. (DESC OCEDURE	RIBE FULLY)			0	PEN OR CLOSED REDUCTION
						PEN CLOSED
	ME OF CILITY					
GIVE DATES OF TREATMENT AND NATURE OF 1						
OFFICE DATE (MM/DD/YYYY)	NATURE OF TREATMENT					
	NAME OF					
	FACILITY					
EMERGENCY DATE (MM/DD/YYYY) ROOM (ER)	NATURE OF					
/ /	NAME OF					
URGENT DATE (MM/DD/YYYY)	FACILITY					
URGENT DATE (MM/DD/YYYY) CARE FACILITY	NATURE OF TREATMENT					
PACILITY , ,	NAME OF FACILITY					
IS THE PATIENT STILL HOW LONG WAS OR WIL	L PATIENT BE CONTINUO	USLY TOTALLY DISABLI		W LONG WAS OR WILL PA		
UNDER YOUR CARE? (UNABLE TO WORK)? FROM (MM/DD/YYYY)	TUROL	ICH (MM/DD 00000)	Ι'	NLY ABLE TO WORK PART [*] OM (MM/DD/YYYY)		,
YES NO / /	THROC	JGH (MM/DD/YYYY)	FRO	OM (MM/DD/1111)	THROUGH	(MM/DD/YYYY)
PLEASE STATE RESTRICTIONS PLACED ON PAT	TIENT FOR ANY DISABILIT	Y THAT HAS BEEN INDI	CATED.	, , , ,	,	1
IF PATIENT DISABLED ON DATE YOU COMPLET		RETURN TO WORK DA	TE? RET	TURN TO WORK DATE (MM/	DD/YYYY)	
YES NO (IF "YES", GIVE RETU				//		
IF HOSPITALIZED, GIVE NAME AND ADDRESS O HOSPITAL NAME	F HOSPITAL AND DATES C	OF CONFINEMENT.	ADN	MISSION DATE (MM/DD/YYY	Y) DISCHARGE	E DATE (MM/DD/YYYY)
				/ /	/	/
ADDRESS						
OUTV					TATE 710	
CITY				5	TATE ZIP	
PHYSICIAN'S NAME		DEGREE		SIGNATURE		
PHONE NUMBER	FAX NUMBER		DATE (MI	M/DD/YYYY)	STAMP	
				1 1		
ADDRESS						
CITY					STATE ZIP	
	MUST DE EUS	ISHED HNDED AUTHOR	UTV OF SECTION	N 6400 OF THE IPO CORE		
INDIVIDUAL PRACTITIONER'S S.S. NO.	MUST BE FURN			MPLOYER I.D. NO.		

	EMPLOYER'S	STATEMENT	
IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE TH		BY COMPLETING SECTION C - E	MPLOYER'S STATEMENT. PLEASE NOTE: IF THE INSURED
EMPLOYEE'S FIRST NAME	LAST NA	AME	M.I.
EMILEOTEE OT INCI NAME	EROTINA	NIIL .	
CITY			STATE ZIP
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	\$ 7
POLICY NUMBER(S)			
EMPLOYEE'S OCCUPATION		DESCRIPTION OF OCCUPATION	'S PRIMARY DUTIES
EMILEGIES GOODLANDA		DESCRIPTION OF GOOD ATION	OTRIMANI BOTILO
WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY?	YES NO PAID	? YES NO	
IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBE	ER OF COMPENSATION CARRIER	. ALSO, SEND REPORT OF INITIAL	L INJURY.
NAME			
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
нн м м н н	IVI IVI		им нимм
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-DISABILIT	TY INCOME? YES NO	IF NO, WHAT PERCENTAGE?%
DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILIT	ΓΥ)		
EMPLOYER CONTACT NAME	CONTACT'S POSITION		DATE (MM/DD/YYYY)
SIGNATURE	PHONE N	UMBER	FAX NUMBER

Combined Insurance Company of America

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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

REQUIRED SIGNATURE OF CLAIMANT

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.

By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

		, , , , , , , , , , , , , , , , , , , ,	,
X			
	CLAIMANT'S SIGNATURE	DATE	PLEASE PRINT NAME
	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.



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 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 1-800-544-9382, 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.

Combined Insurance Company of America



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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

Print Name

Signature

E-mail Address

Date

future reference.