Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

GROUP LONG TERM DISABILITY CLAIM APPLICATION

Send completed application to:

Claims Department
PO Box 1230
Enfield, CT 06083
Toll Free Number: 1-877-377-6773
Fax Number: 1-877-737-3650

To avoid unnecessary delays, please follow these instructions when applying for disability benefits.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

All four sections of this claim application must be completed:

Section 1:	*Authorization and Disclosures* (to be completed by the employee)
Section 2:	*Employee's Statement* (If you have already returned to work full-time or if you are filing a maternity claim, only complete questions #1 through #15. For all other claims, answer all questions in this section)
Section 3:	*Employer's Statement*
Section 4:	*Physician's Statement*

When ALL sections of this form have been completed, please fax or mail it to us. Use the fax number or address above that corresponds to the type of disability for which you are applying.

It is your responsibility and the responsibility of your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

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Authorization and Disclosures

Section 1: To Be Completed By Employee

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

TO:

- Physicians and other Medical Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
- Group Policyholders, Contract Holders/Vendors, Health Benefit Plan Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers and Pre-Paid Health Plans
- Pharmacies
- State Vocational Rehabilitation agencies and other providers of Rehabilitation Services
- Attorney Representatives

You are authorized to provide any information related to my medical condition and to job modifications/accommodations with my current or future employer to:

- Symetra Life Insurance Company in partnership with Custom Disability Solutions ("CDS"),
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, and service consultants and other personnel involved in the administration, evaluation, analysis and management of the plan and/or claim.

This includes, but is not limited to, any:

- Records, test results, data, and information about medical care, history, diagnosis, prognosis, treatment, and supplies;
- Employment-related information;
- Income-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, analyzing, managing and / or administering my claim for long term disability benefits, salary continuation, workers' compensation and/or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), for assessing and developing a vocational rehabilitation plan, and for other business purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program plan under which I may be a participant, claims investigators, attorneys, service consultants and any other entities, including the claimant's treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization will no longer be protected under HIPAA.

I understand that this authorization shall remain in force for the duration of my claim for benefits under the Benefits Program or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed. ***I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of my initial authorization, may impair the ability of Symetra Life Insurance Company, in partnership with any claim administrator to process my claim and may be a basis for denying or terminating my claim for benefits***.

Claimant's Signature: _____ Date: _____ Date of Birth: _____

Claimant's Full Name: _____ Employer: _____

If the insured is unable to sign, an authorized representative may sign below for the insured.

Representative Signature: _____ Date: _____

Description of Representative's Authority to Sign: _____

Section 1: Continued

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: 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.

AR, LA, RI, WV: 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.

AZ: 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.

CA: For your protection California law requires the following to appear hereon: 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.

CO: 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.

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

DC: 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.

FL: 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.

ME: 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.

MD: 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.

NH: 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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: The following applies to health insurance only: 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.

OK: 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.

PA: 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.

TN, VA, WA: 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.

TX: 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.

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Employee's Statement

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1	Employee Name			2 Social Security No.
	Street/Box/Apt.			3 Phone No. ( )
	City, State, Zip			4 Date of Birth
5	Height	6 Weight	7 ☐ Male ☐ Female	8 Employer Name
9	Occupation	10 List Occupation Duties		
11	Date of accident or date of first symptoms	12 Last Day Worked	13 Are you unable to work due to: (check one) ☐ Injury ☐ Illness ☐ Pregnancy	
14	Date you Returned to Work		☐ Full Time ☐ Part Time	
15	If you have not returned to work, when do you expect to return?		☐ Full Time ☐ Part Time	

16 Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms

17 Is your accident or illness related to your occupation? ☐ Yes ☐ No
If yes, explain:

18 Have you filed a Workers' Compensation Claim? ☐ Yes ☐ No If no, do you intend to? ☐ Yes ☐ No
If no, explain:

19 When were you first treated for your illness or accident?

Hospital	Address	Date(s)
Doctor	Address	Date(s)

20 Have you ever had same or similar condition in the past? ☐ Yes ☐ No If yes, list name and address of Hospital/Doctor below

Hospital	Address	Date(s)
Doctor	Address	Date(s)

21 Are you receiving any of the following? (Check each benefit you are receiving)

	Amount	Begin date	End date		Amount	Begin date	End date
☐ Workers' Compensation	$_____	_____	_____	☐ Unemployment	$_____	_____	_____
☐ Social Security	$_____	_____	_____	☐ Other (Indiv. or Group)*	$_____	_____	_____
☐ State Disability	$_____	_____	_____	☐ Auto Ins. Wage Replacement*	$_____	_____	_____
☐ Canadian Pension Plan	$_____	_____	_____				

*If yes, give name and address of Insurer below

Insurer Name(s)	Address		
22 ☐ Single ☐ Married ☐ Divorced ☐ Widowed	23 If married, spouse's name and Social Security No.	24 Spouse Date of Birth	
25 Is Spouse Employed? ☐ Yes ☐ No	26 List children under age 25 (Names and Dates of Birth)		

27 If benefits are approved, do you want the minimum $88.00 per month withheld from your check for Federal Income Tax purposes? ☐ Yes ☐ No
If you want more withheld, please state dollar amount you want withheld $ _____

By signing below, I attest that I have read and understood the fraud warning applicable to me. I also attest that the statements above are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Signature X _____ Date _____

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Employer's Statement

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1	Employee's Name		2 Social Security No.
	Street/Box/Apt.		3 Date of Birth
	City, State, Zip		4 Regularly Scheduled Hours Per Week
5	Date of Hire	6 Employee's LTD Effective Date	7 Occupation
8	Policy No.	9 Policy Division No.	10 Policy Class

11 Employee's Work Schedule ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal

12 Check Regular Workdays ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

13 If not at work when disability began, check status and provide date
☐ Terminated ☐ Leave of Absence ☐ Other: _____
☐ Laid Off ☐ Sick Leave
☐ Vacation ☐ Resigned
Date _____

14 How was employee paid? (check frequency and types)
Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly
Type(s): ☐ Hourly ☐ Bonus ☐ Salary ☐ Commission

15 Salary Prior to Date Last Worked
Base Weekly Wages $ _____
W-2 Earnings $ _____
Overtime $ _____
Commissions $ _____
Bonus $ _____

16 Date Last Salary Increase

17 Employee Work Schedule at Time Last Worked
_____ Days per week
_____ Hours per week

18 Date Last Worked	19 Hours Worked That Day	20 First Day Out	21 Has Employee Returned to work? ☐ Yes ☐ No ☐ Full Time ☐ Part Time If yes, Date _____

22 Date Paid Through _____ For ☐ Salary Continuation ☐ Vacation ☐ Accrued Sick Pay

23 Does employee contribute toward the LTD premium? ☐ Yes ☐ No If yes, ☐ Pre-Tax ☐ Post-Tax

If Post Tax, _____% paid by employer _____% paid by employee

24 Employee is Eligible for:	Yes	No	If yes, Weekly or Monthly Amount	Wk	Mo	Provider Name/Address	Date Benefits Begin	Through
Salary Continuation	☐	☐	$	☐	☐			
Disability Pension	☐	☐	$	☐	☐			
Retirement Pension	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Unemployment	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Workers' Compensation	☐	☐	$	☐	☐			
Has Workers' Comp. claim been filed?	☐	☐	If Workers' Compensation has been denied, submit copy of denial with this claim.					

25 Does your company have a rehire or return to work policy for disabled employees? ☐ Yes ☐ No

What is the name of the person we should contact if we identify a return to work option?

26 Employee's medical insurance carrier or HMO (provide policy or ID No.)

Name _____

Address _____

A Job Description is required if employee is out of work more than 6 weeks.

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Employer's Statement

Section 3: Continued

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

27 Notice to Employers – Tax Services.
We will provide the tax services agreed upon at the time the policy was sold. Please contact the Claims Department if you have any questions regarding the specific Tax Services provided by Symetra.

Symetra LTD Tax Services: Our standard services include issuing checks to the claimants in arrears, withholding employee taxes if the benefit is taxable, paying the employer matching FICA, and preparing W-2s.

FICA taxes are applicable only for the first six calendar months from the last day worked and only if the benefit is taxable. The benefit is taxable if the employer paid all the premium or if the claimant paid the premium with pre-tax or grossed up dollars (considered employer paid). If the claimant paid all the premiums with post-tax dollars, then the benefit is non-taxable. If the premium payments are shared, then the benefit is taxable for the percentage that the employer paid the premium. FICA withholding is mandatory on all portions of the benefit paid with a pre-tax premium.

28 Employer's Name		Phone No. ( )	
Street Address	City	State	Zip
Signature (The above statements are true and complete to the best of my knowledge) X		Date	

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Physician's Statement

Section 4: To Be Completed By Physician

Patient Name		Date of Birth	Social Security No.
Height	Weight	Blood Pressure (last visit)	

1 Patient is/was unable to work due to: (check one) ☐ Injury ☐ Illness ☐ Pregnancy

2 Diagnosis (include complications and ICD 9 or ICD 10 codes)

For Normal Pregnancy, complete items 3-6, then skip to item 25

3 What was LMP date?	4 What is the expected date of delivery?	5 Date First Treated	6 Date Last Treated

For all conditions except Normal Pregnancy, complete the following items

7 When did symptoms first appear or accident happen?	8 Date you advised patient to stop working	9 Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No

10 Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe

11 Date of First Visit	12 Date Last Visit	13 Frequency of Visits

14 Objective Findings (X-rays, EKG's, lab data and clinical findings) If needed, use a separate page and to also include copies of lab and test results and office notes	15 Subjective Symptoms

16 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency

17 Names and addresses of other physicians

18 Has patient been hospitalized? ☐ Yes ☐ No If Yes, give name and address

From _____ to _____

19 Restrictions (what the patient **SHOULD NOT** do)	20 Limitations (what the patient **CANNOT** do)

21 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis

I

II

III

IV

V

22 If this is a cardiac condition, what is the functional capacity? (American Heart Association)
☐ Class 1 - No Limitation ☐ Class 2 - Slight Limitation ☐ Class 3 - Marked Limitation ☐ Class 4 - Complete Limitation

23
Patient released to return to work with restrictions Date_____
Estimated return to work without restrictions Date_____
Restrictions effective through Date_____
Has patient reached maximum medical improvement? ☐ Yes ☐ No Date_____
Are the above restrictions permanent? ☐ Yes ☐ No Date_____
Can patient work full time? ☐ Yes ☐ No Part Time_____hrs/day Date_____

24 If employer can accommodate patient's limitations and restrictions, is patient able to return to work? ☐ Yes ☐ No If yes, what date could employment begin?

25 Physician Name (Please Print)			Degree
Specialty		Phone No.	Fax No.
Address	City	State	Zip
Signature (No Stamp) X		Tax ID No.	Date