BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492

FAMILY MATTERS. NO MATTER WHAT.®

DISABILITY INCOME AND/OR WAIVER OF PREMIUM CLAIM KIT

INSTRUCTIONS FOR FILING A DISABILITY INCOME AND/OR WAIVER OF PREMIUM CLAIM

You may be eligible for benefits following a waiting period. If you anticipate that your disability will extend beyond the waiting period, please submit your claim now.

Be sure to continue to pay premiums until a decision is made on your claim.

1. Please complete **all sections** of the claim form.
    - Policyholder's statement of claim
    - Description of occupation
    - Educational/Work Experience

2. Please complete the **top section** of the Attending Physician's Statement. **(Name, Social Security Number and Policy Number)**

    Please give the Attending Physician's Statement to your doctor to complete.

    Your attending physician should fully complete both pages of the Attending Physician's Statement. A physician who can certify your total disability should complete this section.

3. Please complete the HIPAA authorization form.

4. Please read the "Fraud Warning Notice" for your state.

5. If you wish to receive your proceeds via direct deposit to your banking account, please be sure to complete the enclosed EFT Authorization form and include it with your other claim paperwork when you send it in.

Please be sure to fully complete all forms to prevent unnecessary delays in processing your claim.

If you should need assistance in the completion of the claim form please call 877-212-2950
Mail forms to: Boston Mutual Life Insurance Company – 120 Royall Street • Canton, MA 02021
Or send forms via secure email to: claimsdept@bostonmutual.com
Or fax forms to: 781-770-0492

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POLICYHOLDER'S STATEMENT OF CLAIM

(If you need more space, please use the back of this form)

Insured's Name *(all known names)* ______________________________

Social Security No. ____________ Date of Birth ____________ Telephone No. ____________

Home Address ______________________________
Street *City or Town* *State* *Zip Code*

Policy Number(s) ______________________________

Last day worked ________ When did your disability start? ________ When do you expect to return to work? ________

Nature of Illness or Injury ______________________________

If Accident - Date and Time ____________ Place ____________

Did Accident occur at work? ____________ When did you first know you had this condition? ____________

How did injury occur? ______________________________

If pregnant, provide due date: ______________________________

If hospitalized, give name and address of hospital(s) ______________________________

____

Dates confined to hospital(s) ______________________________

Name of family physician, address and telephone number ______________________________

Name of other physician(s), addresses and telephone numbers ______________________________

Gross monthly income before disability $ ____________ Current Monthly Income $ ____________

	Applied	Date	Denied	Appealing	Company/Agency – Claim No.
Worker's Compensation	❑		❑	❑	
Social Security	❑		❑	❑	
Other Disability Benefits *(Group, LDT, etc.)*	❑		❑	❑	
State Disability	❑		❑	❑	
Retirement or Pension Plan	❑		❑	❑	
Private Insurance Plan	❑		❑	❑	
Other	❑		❑	❑	

Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, consumer reporting agency, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Boston Mutual Life Insurance Company, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Boston Mutual Life Insurance Company to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Boston Mutual Life Insurance Company to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Boston Mutual Life Insurance Company to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Boston Mutual Life Insurance Company Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.

X ______________________________ ______________________________
Signature Date

BOSTON MUTUAL LIFE INSURANCE COMPANY

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DESCRIPTION OF OCCUPATION

Insured's Name: ______________________ Policy No. ______________

Please fully describe the occupational duties that you were performing immediately prior to your disability.

Employer: ______________________ Telephone No: (   ) __________ Date of Hire __________

Employer's Address: ______________________

Normal hours worked each week: From __________ To __________ Your job title: ______________

How many years have you worked in this occupation? ________ How long have you performed the duties listed below? ________

Your monthly earned income immediately preceding your disability: ______________________

Do you have any other part time jobs? YES ❑ NO ❑ If yes, please explain. ______________________

DAILY OCCUPATIONAL DUTIES

List and describe the most important duties first	Hours per week
1.	
2.	
3.	
4.	
5.	

INSTRUMENTS AND EQUIPMENT USED

List those used most frequently first	Hours per week
1.	
2.	
3.	
4.	
5.	

Where do you work? Mostly indoors ❑ Mostly outdoors ❑ Equally in and out ❑

If there is any additional information about your job that you believe will help us to understand the occupational duties you were performing, please explain *(use back of this form if necessary).*

____

____

____

PHYSICAL REQUIREMENTS OF YOUR OCCUPATION

	Occasionally	Frequently	Constantly
Bending	❑	❑	❑
Reaching	❑	❑	❑
Lifting	❑	❑	❑
Carrying	❑	❑	❑

Maximum weight you lift or carry:	10 lbs ❑	20 lbs ❑	50 lbs ❑	100 lbs ❑
Maximum weight you most frequently lift or carry:	10 lbs ❑	20 lbs ❑	50 lbs ❑	100 lbs ❑

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Signature Date

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EDUCATION / WORK EXPERIENCE

Insured's Name: ______________________________ Policy No: ______________

Please complete this form to the best of your ability. Use an additional sheet of paper is you need more space.

EDUCATIONAL BACKGROUND

Highest grade completed: ____________

Did you attend college or other school of higher learning? YES ❑ NO ❑

If yes, name of institution: ______________________________

Degree(s) or Certificate(s): ______________________________

Major field(s) of study: ______________________________

WORK EXPERIENCE

List chronologically the jobs you have had as an adult and indicate:

1. Type of work. Be specific: *i.e. sales, accountant, clerk, laborer, etc.*
2. Physical Requirements: *i.e. heavy lifting, standing, sitting, etc.*
3. Supervisory Experience

Dates	Type of Work	Physical Requirements	Supervisory Experience
			YES ❑ NO ❑
			YES ❑ NO ❑
			YES ❑ NO ❑
			YES ❑ NO ❑

Additional courses taken, special skills, or hobbies. ***Please be specific, such as carpentry, auto repair, etc.***

____

____

____

____

____

____

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X ______________________________ ______________
Signature Date

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ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY INSURED

Insured: ______________________ **Social Security No:** __________ **Policy No:** __________

TO BE COMPLETED BY ATTENDING PHYSICIAN

HISTORY

Patient's symptoms result from *(check all that apply)*

❑ Employment ❑ Illness ❑ Pregnancy (Due Date: __________) ❑ Auto Accident ❑ Other Accident

Date Symptoms first appeared or date of accident/injury: __________ Date total disability commenced: __________

Date patient first consulted you for this condition: __________ Date of most recent visit: __________

Frequency of visits: ❑ Weekly ❑ Monthly Other *(please specify)* __________

Has patient had same or similar condition: ❑ YES ❑ NO If yes, Please explain: __________

Name(s) and addresses of other treating or referring physician(s) __________

Hospital name: __________ Confinement Dates: __________ thru __________

DIAGNOSIS

Diagnosis *(including any complications or secondary diagnoses)* __________

Subjective Symptoms: __________

Objective finding *(include results/copies of x-rays, lab tests, EKGs, MRIs and scans)* __________

TREATMENT & PROGRESS

Please describe present treatment plan: *(including surgery, physical therapy or psychotherapy)*

Please advise all medications prescribed:

IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING HER/HIS OCCUPATION? ❑ YES ❑ NO

IS PATIENT NOW TOTALLY DISABLED FROM PERFORMING ANY OCCUPATION? ❑ YES ❑ NO

When was or will patient be able to resume ANY PART of her/his work? __________

When was or will patient be able to resume ALL of her/his work? __________

Please describe any temporary restrictions and/or any return to work plan: __________

CARDIAC

(Complete only if applicable)

Functional Capacity:

❑ Class 1 *(no limitation)* ❑ Class 2 *(slight limitation)* ❑ Class 3 *(marked limitation)* ❑ Class 4 *(complete limitation)*

Blood Pressure *(latest reading)* __________ as of *(date)* __________

Is patient in a cardiac rehabilitation program? ❑ YES ❑ NO

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CONTINUATION OF ATTENDING PHYSICIAN'S STATEMENT

Insured: ______________ **Social Security No:** ______________ **Policy No:** ______________

TO BE COMPLETED BY ATTENDING PHYSICIAN

PHYSICAL IMPAIRMENT

(Complete only if applicable)

- ❑ **CLASS 1 –** No limitation of functional capacity; capable of heavy work. No restrictions. **0 -10%**
- ❑ **CLASS 2 –** Medium manual activity. **15 -30%**
- ❑ **CLASS 3 –** Slight limitation of functional capacity; capable of light work. **35 -55%**
- ❑ **CLASS 4 –** Moderate limitation of functional capacity; capable of clerical/administrative *(sedentary)* activity. **60 -70%**
- ❑ **CLASS 5 –** Severe limitation of functional capacity; incapable of minimal *(sedentary)* activity. **75 -100%**

Remarks: ______________

PSYCHIATRIC IMPAIRMENT

(Complete only if applicable)

a) Please define "stress" as it applies to this claimant. ______________

b) What stress and problems in interpersonal relations has claimant had on job? ______________

- ❑ **CLASS 1 –** No limitation of functional capacity; capable of heavy work. No restrictions. **0 -10%**
- ❑ **CLASS 2 –** Medium manual activity. **15 -30%**
- ❑ **CLASS 3 –** Slight limitation of functional capacity; capable of light work. **35 -55%**
- ❑ **CLASS 4 –** Moderate limitation of functional capacity; capable of clerical/administrative *(sedentary)* activity. **60 -70%**
- ❑ **CLASS 5 –** Severe limitation of functional capacity; incapable of minimal *(sedentary)* activity. **75 -100%**

Remarks: ______________

PROGNOSIS

Prognosis: ❑ Terminal ❑ Poor ❑ Good ❑ Excellent

Has patient reached maximum medical improvement? ❑ YES ❑ NO

When could trial of employment commence: Part-Time ______________ Full-Time ______________

REHABILITATION

Is patient a suitable candidate for rehabilitation services? ❑ YES ❑ NO

Please Explain: ______________

Would job modification enable patient to work with impairment? ❑ YES ❑ NO

Please Explain: ______________

Would vocational counseling and/or retraining be recommended? ❑ YES ❑ NO

Please Explain: ______________

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X ______________ ______________
Signature Date

Physician's Name: ______________ Degree or Specialty: ______________

Address: ______________
Street *City or Town* *State* *Zip Code*

Telephone Number: ( ) ______________ Fax Number: ( ) ______________

Signature: ______________ Date: ______________

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Name: ______________________________ Policy No: ______________

Complete the information below to authorize Boston Mutual Life Insurance Company *("Boston Mutual")* to directly deposit your benefits into the bank account referenced below via Automated Clearing House (ACH)/Electronic Funds Transfer (EFT). A voided check or signed specification *(spec)* sheet/letter of instruction from the bank must be submitted with this form. Deposit slips and starter checks will not be accepted.

Bank Account Type: *(select one)* ❑ Checking Account ❑ Savings Account

Full Legal Name on Bank Account: ______________________________

Name of Bank/Financial Institution: ______________________________

Bank routing/ABA Transit # *(9 digits)*: ______________________________

Account #: ______________________________

This authority is to remain in full force and effect until Boston Mutual has received written notification from me of its termination in such time and in such manner as to afford Boston Mutual and the Bank/Financial Institution a reasonable opportunity to act on it.

Disclosures

- Boston Mutual shall incur no liability as a result of a deposit being dishonored by your bank.
- If Boston Mutual cannot make a deposit into the designated bank account via ACH/EFT for any reason, we reserve the right to mail a check to the claimant/beneficiary at the address of record.
- ACH/EFT is only available for U.S.-based banks or participating credit unions.
- It may take up to 2-3 business days from the date the disbursement is processed for your bank to reflect the deposit.

I authorize Boston Mutual to deposit funds into the designated bank account through an ACH/EFT. I agree that if there is an overpayment on my claim, I will promptly refund the full amount of any such overpayment by check.

Date: ______________ Signature of Claimant/Beneficiary: ______________________________

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company

(Herein referred to as "we", "us", "our")

FAMILY MATTERS. NO MATTER WHAT.®

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us

- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf

- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

FRAUD WARNING NOTICES – For Use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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 information to obtain or amend insurance coverage or to make a 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 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 NH Rev. Stat. Ann. §638:20.

see other side

FRAUD WARNING NOTICES – For Use with Claim Forms *(cont.)*
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of 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.

OREGON: 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 may be guilty of insurance fraud.

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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are 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: ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED THE STATE LAW.

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 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.