



# Group Claim Form- Permanent & Total Disability- Life Insurance

Submit to: Aetna Life Insurance Company  
 PO Box 14548  
 Lexington, KY 40512-4548  
 Phone: 800-523-5065  
 Fax: 800-238-6239

## Claimant

## Employer

- Claimant completes Sections 1 – 3 and signs the release in Section 3 and the bottom of Page 2.
- Please submit this form with a properly completed Attending Physician's Statement to the above address.
- Forms without signatures will be returned.

- Employer completes section 4.
- If the Claimant has Supplemental Insurance, you must submit the enrollment forms and/or screen prints for the current year as of date last worked and 2 years prior.
- Forms without signatures will be returned.

### 1. Claimant Information

Employer Name				Work Location and/or Union affiliation	
Claimant's Name			Birth date (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street)		City	State	Zip Code	Daytime Telephone Number ( )
Occupation			Cause of Disability		

### 2. Attending Physician Information (Attach additional sheet if more space if needed.)

Physician's Name			Condition(s) Treated		
Address (Street)		City	State	Zip Code	Daytime Telephone Number ( )
Physician's Name			Condition(s) Treated		
Address (Street)		City	State	Zip Code	Daytime Telephone Number ( )

### 3. Release

To all providers of health care:  
 You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original

Claimant Signature	Date
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### 4. Employer Information

Basic Life Control Number		Control Suffix	Claim Account	Plan	Amount of Basic Insurance in Force on Date Last Worked \$
Supplemental Life Control Number		Control Suffix	Claim Account	Plan	Amount of Supplemental Insurance in Force on Date Last Worked \$
Claimant is <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	Rate of Basic Earnings on Date Last Worked Annually \$	Date Last Worked / /		Date Claimant First Began Work / /	
Reason Claimant Did Not Return to Work After Last Day Worked				Claimant's Social Security Number - -	
Type of Provision (check one): <input type="checkbox"/> Premium Waiver <input type="checkbox"/> DBO-AID <input type="checkbox"/> Lump Sum <input type="checkbox"/> Group Universal Life <input type="checkbox"/> PTD/ Installment		Date Insurance Took Effect / /		Effective Date Insurance Discontinued if Not in Force / /	
Was Claimant Required to Submit Evidence of Insurability? <input type="checkbox"/> No <input type="checkbox"/> Yes, give date submitted			Supplemental Insurance Required Information: Enrollment forms and/or Screen Prints for current year as of date last worked and 2 years prior.		
Last Contribution Covered Period Ending (complete only if claimant contributed part of premium)			If Retired, Provide Retirement Date and Copy of Pension Acceptance.		
Employer's Address (Street)		City	State	Zip Code	Telephone Number ( )
Printed Name of Employer's Authorized Representative				Email Address	
Signature of Employer's Authorized Representative				Date / /	

**5. Misrepresentation**

Any person who knowingly and with intent to injure, defraud or deceive 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.

**Attention Arkansas, Louisiana, Rhode Island and West Virginia Residents:** 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.

**Attention California Residents:** For your protection, California law requires notice of the following to appear on this form: 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.

**Attention Colorado Residents:** 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.

**Attention Florida Residents:** 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.

**Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Kentucky Residents:** 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 may subject such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** 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 denial of insurance benefits.

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

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

**Attention New York Residents, the following statement applies only to your AD&D coverage:** 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

**Attention Ohio and Pennsylvania Residents:** 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.

**Attention Oklahoma Residents:** 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.

**Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

**Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Washington Residents:** 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.

I acknowledge that I have read the fraud notices above and I affirm that the answers on this form are complete and true to the best of my knowledge and belief.

Claimant's Signature

Date (MM/DD/YYYY)



# Attending Physician's Statement

## Permanent and Total Disability – Life Insurance

**Patient Instructions:** The Patient will complete Section 1 and fill in their name at the top of Pages 2, 3 and 4.

**The Patient must sign on the bottom of page 4.**

The **Patient** is responsible for completing this section, and for **ensuring that their Attending Physician completes the remainder of this statement.** The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 1-800- 523-5065.**

### 1. Patient Information

(a) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Patient Name (Last, First, Middle Initial)      Social Security Number      Birth Date (MM/DD/YYYY)      Height-Weight(lb)

(b) Patient Gender  Male     Female

(c) Patient Home Address Required (Current No., St., Town, State, Zip – no PO boxes) \_\_\_\_\_  Check if New

(d) Patient Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_  Check if New

(e) Mailing Address, if different from Home address \_\_\_\_\_

(f) Patient Employer (Name/City/State) \_\_\_\_\_

(g) Job Title Occupation \_\_\_\_\_

### 2. Physician Instructions - The Physician will complete Sections 2 through 7.

The **Attending Physician** should complete the items below, based upon a **recent examination.** Attach additional documentation as needed.

**This is a time-sensitive document. A delay in returning a completed Attending Physician's Statement could result in your patient's disqualification from receiving valuable insurance benefits.**

Your patient has applied for a benefit under the Permanent and Total Disability provision of a group life insurance policy. Please provide us with the following information so that we can determine your patient's eligibility for the benefit. If you have any questions, please call **1-800-523-5065.**

**Please complete form in its entirety and fax to 1-800-238-6239. Pages 2 and 3 MUST be completed before faxing.**

### 3. Impairing Diagnosis & Treatment

(a) For medical reasons, the patient will need to be absent from work due to a disability beginning on \_\_\_\_\_ and ending on \_\_\_\_\_  
 (MM/DD/YYYY)      (MM/DD/YYYY)

**REQUIRED:**

(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
 Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
 Other Diagnoses \_\_\_\_\_ Other ICD Code \_\_\_\_\_

(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_

(d) Surgery Date \_\_\_\_\_

Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
 Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
 Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(e) Medication(s)/Dose/Frequency \_\_\_\_\_  
 \_\_\_\_\_  
 Impairment from medication effects \_\_\_\_\_

(f) Other Treating Physicians

Name _____	Specialty _____	City _____	State _____
Name _____	Specialty _____	City _____	State _____
Name _____	Specialty _____	City _____	State _____

Patient Name (Last, First Middle Initial) Required

**4. History**

(a) Symptoms and severity:  
\_\_\_\_\_  
\_\_\_\_\_

(b) Date symptoms first appeared or accident happened \_\_\_\_\_

(c) Has patient ever had same or similar condition?  No  Yes, state when and describe.  
\_\_\_\_\_

(d) Is condition due to injury or sickness arising out of patient's employment?  No  Yes  Unknown

(e) Is patient still under your care for this condition?  No  Yes, date service terminated \_\_\_\_\_  
(MM/DD/YYYY)

(f) Treatment summary:  
\_\_\_\_\_  
\_\_\_\_\_

(g) Office visit dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(h) Was patient recently hospitalized?  No  Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(i) Hospital Name/City/State  
\_\_\_\_\_

**5. Current Status**

(a) Patient has .....  Improved  Stabilized  Regressed  Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
 No  Yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work?  No  Yes

Patient Name (Last, First Middle Initial) Required

6. Abilities/Limitations

(a) Patient is: Place remarks in item (e) below, if applicable.

- Competent to endorse checks and direct the use of proceeds thereof
• Able to work with others
• Able to give supervision
• Able to work cooperatively with others in group setting
• Able to do? Select one: Place remarks in item (e) below, if applicable.
- Heavy work activity. No limitations of functional capacity.
- Medium work activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly
- Light work activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently
- Sedentary work activity - moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- No ability to work. Severe limitation of functional capacity; incapable of minimal activity
- Other. Place remarks in item (e) below.

(b) What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)

- Number of Hours patient is capable of working in a day: 12 10 8 6 4 2 1 Hours/Day
• Number of Days per week patient is able to work: 1 2 3 4 5 6 7 Days/Week
• Date you prescribed restriction on work activities: Month Day Year
• How long are these restrictions/limitations in effect? Days Weeks Months No Longer
• Estimated return to work date? (MM/DD/YYYY) modified duty (MM/DD/YYYY) full duty

(c) Objective findings that substantiate impairment (current laboratory, physical and/or mental status examination, and other testing)

(d) Subjective findings that substantiate impairment:

(e) Other/Comments:

7. Physician Information

Table with 4 rows and 3 columns: Physician's Name (please print), Degree, Specialty/Board Certification; Address, Telephone Number, Fax Number; Taxpayer Identification Number; Signature, Date.

Please mail or fax this completed questionnaire to: Aetna Life Insurance Service Center, PO Box 14548, Lexington, KY 40512-4548, Fax Number: 1-800-238-6239

If you have any questions please call our Customer Service Unit at 1-800-523-5065.

Patient Name (Last, First Middle Initial) Required

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**Attention Washington Residents:** 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.

I affirm that the answers on this form are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notices listed above.

Employee Signature

Date