FORT DEARBORN LIFE
Insurance Company

Claim Form

Phone Number: (800) 348-4510
Fax: (630) 824-5419

Return to Fort Dearborn Life at:
Attention: Claims Department
1020 31st Street
Downers Grove, Illinois 60515-5591

GROUP NUMBER _____

PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED

- ☐ SHORT-TERM DISABILITY
- ☐ VOLUNTARY STD
- ☐ WAIVER OF PREMIUM
- ☐ ACCIDENTAL DISMEMBERMENT
- ☐ SPECIFIC DISEASE BENEFIT
- ☐ ACCELERATED DEATH BENEFIT
- ☐ CRITICAL ILLNESS

CLAIMANT'S STATEMENT (Please Print)

Claimant's Name	Social Security #	Height	Weight	Birth Date

Address
Number Street City State Zip

Phone Number
A/C ( )

E-mail

Name of employer	Occupation	Maiden Name	Alias Name

Are you filing a claim for this disability under the Workers' Compensation Act? ☐ Yes ☐ No

Are you filing a claim for this disability under the Social Security Act? ☐ Yes ☐ No

Describe other income you are receiving:

YES	NO	TYPE *	AMOUNT	DATE BENEFITS BEGAN	DATE BENEFITS TERMINATED	NAME OF INSURANCE CARRIER
☐	☐	Social Security (disability or retirement)	$ _____	_____	_____	
☐	☐	State disability	$ _____	_____	_____	
☐	☐	Retirement (normal, early or disability)	$ _____	_____	_____	
☐	☐	Workers' Compensation	$ _____	_____	_____	_____
☐	☐	Group disability benefits	$ _____	_____	_____	_____
☐	☐	Other (describe) _____	$ _____	_____	_____	

**Please send a copy of your award letter, if applicable.*

1. Date of accident or beginning of sickness:_____ Date last worked: _____
2. Nature of injury or illness: _____
3. If injury, describe how, when and where accident occurred: _____
4. Have you ever had same or similar illness? ☐ Yes ☐ No If yes, give dates: From _____ To _____
5. Name of hospital(s): _____ Dates confined: From _____ To _____
   Address of hospital(s): _____
6. Name and address of Doctor(s): _____
   Dates of treatment: _____
7. Between what dates were you unable to perform any duties? From_____ To_____ From_____ To_____

AGREEMENTS AND AUTHORIZATION: I authorize my employer to disclose all information necessary to process my claim to Fort Dearborn Life Insurance Company (FDL).
I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's claim department or its authorized representative(s) information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize FDL to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.
This authorization shall expire on the date that I receive notice of FDL's final decision on my claim. I understand and agree that:
· I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
· Information disclosed may be redisclosed and no longer protected by federal privacy laws;
· I should retain a duplicate copy of this authorization for my own records.;
· A photocopy of this authorization shall be as valid as the original;
I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from FDL.
If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny my claim.
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. (Not enforceable in Oregon or Virginia.)

Signature of Employee_____ Date_____

R3/07 I Z4676 (IL)

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Employers Statement (**italicized items should only be completed if the claim is for Waiver of Premium)

Employee's Name	Social Security #	Date of Hire	Effective date of Employee's insurance
Employer's Name			Employer's Group Number
Employer's Address			
Employer's E-mail Address			

Last Day Worked ☐ FT ☐ PT	Date returned ☐ FT ☐ PT	Base salary ☐ Hourly $ _____ ☐ Weekly ☐ Monthly	Class	Hours worked per week

Worker's Comp Claim filed for this Disability? ☐ Yes ☐ No	SELF ADMINISTERED ONLY: Amount of weekly disability benefit: $_____	Claimant received: Salary continuation through _____
Employee's Occupation		Vacation through _____ Sick Pay through _____

Premium contribution % by Employer _____ Employee _____ Employee premiums for this coverage pre-taxed? ☐ Yes ☐ No

**Amount of Life Insurance in force:	**Through what date were premiums paid:	**Normal retirement age:

Signature	Title	Date	Telephone ( )

ATTENDING PHYSICIAN'S STATEMENT

(Must be completed in full at the patient's expense)

Patient's Name _____ Street Address _____ City _____ State _____ Zip _____	☐ Male ☐ Female	Date of Birth	Age

1. Nature and origin of ☐ sickness ☐ injury Diagnosis (describe complications, if any): _____
2. Date symptoms first appeared or date of accident: _____ Date patient first consulted you for this condition: _____
3. Is this condition work related? ☐ Yes ☐ No _____
4. Describe any other disease or complications effecting present condition: _____
5. Date and surgical procedure(s), if any: _____
6. If maternity give estimated or actual date of delivery: _____ ☐ Vaginal ☐ C-section
7. Please give dates of treatment other than surgical: _____
8. Please give hospital name & address with dates of confinement: From _____ To _____ ☐ Inpatient ☐ Outpatient
   Hospital Name _____ Address _____
9. Has patient ever had same or similar condition? ☐ Yes ☐ No (If yes, state when and describe) _____
10. Is patient still under your care? ☐ Yes ☐ No (If discharged give date and degree of recovery) _____
11. Is the patient under the care of another physician? ☐ Yes ☐ No (If yes, provide name, address and phone # of physician) _____
12. Patient was or will be continuously disabled (unable to work)
    In his/her own occupation From _____ Through _____ In any other occupation From _____ Through _____
    Patient can return to work ☐ Full time ☐ Part time on _____ ☐ Restrictions (specify) _____
13. Patient was or will be partially disabled? _____ From _____ Through _____
14. In your opinion, is patient a candidate for rehabilitation? ☐ Yes ☐ To return to own occupation ☐ For another occupation ☐ No
15. If patient is diagnosed as terminal, is life expectancy: ☐ 6 months or less ☐ 12 months or less ☐ Other _____

Remarks: _____

Physician's Name _____ Office # ( ) _____ Fax # ( ) _____

Physician's Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Specialty: FP ☐ IM ☐ PM&R ☐ Neuro ☐ Ortho ☐ OBG ☐ Psych ☐ Other _____

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FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

Fraud Notices

Administrative Offices: **Downers Grove, Illinois I Cleveland, Ohio I Dallas, Texas**

The laws of some states require us to furnish you with the following notice:

Arizona & New Jersey - Claims

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

Arkansas & Massachusetts

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.

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, Idaho & Oklahoma

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

District of Columbia, Virginia & Washington

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.

Louisiana & 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 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 - Applications

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

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.

Washington

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

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. (not enforceable in OR)