Madison National Life

Insurance Company, Inc.
P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

EMPLOYEE'S STATEMENT OF CLAIM FOR BENEFITS

As your disability insurer we are committed to assisting you in a return to health and to productive employment. Please complete the following form as thoroughly as possible. By accepting forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights and / or defenses. Any incomplete claim form will not be accepted. **We highly recommend that you also provide medical records from each of your treating physicians to help expedite the review of your claim.** Lack of medical records may result in a delay in the review of your claim.

BACKGROUND INFORMATION

Type of benefit this claim is being filed for? (Please check all applicable claims):

☐ **Short Term Disability benefits** ☐ **Long Term Disability benefits** ☐ **Life Insurance Waiver of Premium benefits**

Name (print): _____ Social security number: _____

Address: _____ Telephone number: _____

City: _____ State: _____ Zip: _____ Email address: _____

Date of birth: _____ ☐ Male ☐ Female Height: _____ Weight: _____ ☐ Single ☐ Married

Name and birth date of spouse and all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school or (3) disabled children regardless of age if their disability began before age 22):

_____

_____

Your employer's name: _____ Occupation/Job title: _____

Date of hire: _____ Annual salary: _____

Please indicate the extent of your formal education (*circle one*)

Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School

If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*):

Job title, Employer, City and State	Duties:	Dates worked:
(a)		
(b)		
(c)		
(d)		

CLAIM INFORMATION

Is your claim related to an accident or injury? ☐ No ☐ Yes If yes, date and time of accident or injury: _____

Describe how and where the accident or injury occurred: _____

_____

Is your claim related to your occupation? ☐ No ☐ Yes If yes, have you filed a Worker's Compensation claim? ☐ No ☐ Yes

If you have filed a Workers' Compensation Claim, please indicate the status of your claim as well as your weekly benefit amount if your claim has been approved: _____

If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation Services? ☐ No ☐ Yes ☐ My Workers' Compensation claim is currently being disputed

Is your claim related to an illness ☐ No ☐ Yes If yes, Date symptoms first appeared: _____

Please list all symptoms associated with your claim: _____

_____

Date you ceased work: _____ Have you returned to work? ☐ No ☐ Yes If yes, date returned: _____ ☐ Full-time ☐ Part-time

If you have returned to work part time please indicate the number of hours: _____ per day _____ days per week

Continued on Reverse Side

Name_____ DOB#_____

CLAIM INFORMATION CONTINUED

When do you plan to return to your job either on a full-time or part-time basis? Please explain in detail: _____

Please describe the primary tasks of your occupation: _____

Has your doctor provided work restrictions? ☐ No ☐ Yes If yes, please describe: _____

Can you return to your job or another job with your current employer if accommodations were made? ☐ No ☐ Yes If yes, please describe the accommodation needs: _____

Are there any concerns you have about returning to work? ☐ No ☐ Yes If yes, please describe: _____

MEDICAL INFORMATION

Please provide us with a brief description of your condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work: _____

Date first treated for this condition: _____ Name of physician that provided initial treatment: _____

Have you ever had the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of doctor:

_____
Name Street Address

_____
City State Zip Phone

Have you ever been hospitalized for the same or similar condition in the past? ☐ No ☐ Yes If yes, give name and address of hospital:

_____
Name Street Address

_____
City State Zip Phone

If claim is related to Pregnancy: Expected date of delivery:_____ Actual Date of Delivery:_____ ☐Vaginal ☐C-Section

Were / are there any complications associated with your pregnancy? ☐ No ☐ Yes If yes, please describe: _____

OTHER INCOME BENEFITS / FEDERAL TAXES

Your monthly benefit may be affected by other income benefits received. We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ No	☐ Yes	Social Security Disability or Retirement	☐ No	☐ Yes	Unemployment Benefits	☐ No	☐ Yes
Vacation/Bonus Pay	☐ No	☐ Yes	Retirement Benefits	☐ No	☐ Yes	Other Income Benefits	☐ No	☐ Yes
Automobile No-Fault	☐ No	☐ Yes	Short Term Disability	☐ No	☐ Yes	Workers' Compensation	☐ No	☐ Yes

If you have been awarded any of the above other income benefits, please list the type of benefit, benefit amount, frequency of payment, and benefit effective date:

_____

_____

Have you tried any type of other work since the date your ceased work, as noted above? (either for this employer, another employer or through self-employment) ☐ No ☐ Yes if yes, provide name and address of employer, type of work, when employment began and number of hours worked per week: _____

_____

If your employer pays any portion of the premium or premiums are withheld from your pay on a pre-tax basis, you may elect to have Federal Income Tax withheld from each payment. Federal Tax withholding is not mandatory. Do you want amounts withheld for Federal Tax Purposes? ☐No ☐Yes, If Yes you **must** indicate a dollar amount or percentage that you would like to have withheld from your benefit payment: _____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature _____ **Date**_____

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REIMBURSEMENT AGREEMENT
GROUP DISABILITY INSURANCE BENEFIT
(Please read carefully)

When Madison National Life Insurance Company, Inc. ("MNL") has made benefit payments to you in excess of the amount required by the provisions of this policy, or during periods of time for which you subsequently receive retroactive benefits from any source that may offset your benefits under the group policy, you must, in a timely manner, reimburse MNL for such payments, including duplicate or erroneous payments. In addition and upon request, you must execute and deliver to MNL such documents as may be required and do whatever else is necessary to secure our rights to recover any excess, duplicate, or erroneous payments. Such reimbursement will be due and payable immediately upon our notification to and demand of you. Or, at our option, the subsequent payment of benefits or the refund of any premium owed you by MNL may be reduced or refused as a setoff and applied toward such reimbursement. If you delay in notifying MNL of your receipt of a reimbursable income benefit or in making reimbursement to MNL, MNL will have the right to charge interest at a reasonable rate on the delinquent amount owed to MNL. Our acceptance of premium and other fees, or our providing or paying disability benefits, does not constitute a waiver of our right to enforce the provisions of this agreement and/or the group policy in the future. The provisions of this agreement are in addition to, and not in lieu of, any other rights or remedies available to MNL at law or in equity.

Agreement

If my application for group disability insurance benefits is approved, in consideration of the payment of benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described and provided for in the group policy, I hereby agree to reimburse Madison National Life Insurance Company, Inc. for any and all overpayments made to me under the group disability plan provided by employer. I understand that MNL agrees to make payment in this manner in consideration of my agreement to promptly notify MNL of the amounts and effective dates of any such benefits. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators or assigns under the applicable group policy may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the applicable policy.

With respect to any group life insurance coverage provided me by MNL and in consideration of the foregoing, I hereby assign to MNL, as creditor beneficiary, an amount of such group life insurance equal to the amount of any overpayment which may be outstanding under any applicable group disability policy at the time of death.

In witness of the above, the parties hereto have caused this Agreement to be executed, as of the date indicated.

At _____, _____, this _____day of_____, 20_____
(City of Residence) (State of Residence)

_____
Printed Name of Claimant

_____
Signature of Claimant

_____
Signature of Spouse

_____
Witness (must be over age 18)

Fraud Warnings

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: 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.

CALIFORNIA WARNING: For your protection California law requires 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.

COLORADO WARNING: 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 damage. 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.

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 WARNING: 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.

KENTUCKY WARNING: 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.

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

NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: 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.

WASHINGTON WARNING: 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.

Signature: _____ Date: _____

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Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): _____ **Date of birth:** _____ **Telephone number:** _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

5) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

to: **Madison National Life Insurance Company (address, telephone and fax number documented above)**

This form serves as an authorization for Madison National Life Insurance to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2009 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2009 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature_____ **Date**_____