# Life Waiver of Premium Claim For Group Insurance

EB-LWOP-CLAIM (01/17)

# LIFE WAIVER OF PREMIUM CLAIM
# FILING INSTRUCTIONS

**HAVE YOU…**

1. Completed the **Employee's Statement** in full?

2. Had the physician treating you complete the **Attending Physician's Statement**, and had it returned to you?

3. Had your Employer complete the **Employer's Statement**, and had it returned to you?

4. Read, signed and dated the **Authorization for Release of Information?**

**You are responsible for ensuring all forms are completed and submitted to our office.**

**Forms can be sent to our Claims Team via:**

**Email: Aflacclaims@disabilityrms.com**

**Fax: 1 (866) 376-9480**

**Regular Mail: Aflac Claims**
**300 Southborough Drive**
**Suite 200**
**South Portland, ME 04106**

**If you have any questions, please call our Claims Team at 1 (888) 862-5732.**

Aflac

Employee Name: _____
Employer Name: _____
Group Number: _____

**Fax 1 (866) 376-9480**
**Toll Free Phone 1 (888) 862-5732**

**NOTICE OF CLAIM FOR LIFE WAIVER OF PREMIUM BENEFITS**

## EMPLOYEE'S STATEMENT

**(To be completed by employee. To avoid delay, all questions must be answered)**

| Name of Employee | | | Employee's Social Security number |
|---|---|---|---|
| Employee's street address | City | State | Zip |
| Telephone number | Date of Birth / / | Gender ☐ Male ☐ Female | |
| ☐ Right-Handed ☐ Left-Handed | Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed | Is Spouse Employed? ☐ Yes ☐ No | Number of Dependent Children |

List Names and Dates of Birth of Spouse and Dependent Children

_____

_____

| How many hours were you regularly working per week with your present employer? | Gross Annual Salary: *(During the 12 months just prior to your disability - for this employer only)* | Please indicate how you are paid *(check all that apply)*: |
|---|---|---|
| _____hrs. | $ _____ | ☐ Hourly ☐ Hourly Rate:_____ ☐ Salaried ☐ Other_____ ☐ Includes Commissions or Bonuses ☐ Includes Overtime Pay |

| Employer's Name and Policy Number | | | Employer's Telephone Number |
|---|---|---|---|
| Employer's street address | City | State | Zip |
| Your Occupation & Title | List essential duties of your job at the time of disability | | |

| Date of Injury or Date First Noticed Symptoms of Sickness | Date you last worked because of Disability | Date you returned or expect to return to work on a Part-Time Basis | Date you returned or expect to return to work on a Full-Time Basis |
|---|---|---|---|
| / / | / / | / / | / / |

Please describe all work activity, including Self-Employment, since the start of your disability.

_____ If none, initial here. _____

| Is your injury or sickness related to your occupation? ☐ Yes ☐ No | If "Yes", explain: _____ _____ | Did you file for Workers' Compensation? ☐ Yes ☐ No |
|---|---|---|

Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms.

If more space is needed, please attach sheet of paper._____

_____

_____

| Date First Treated / / | If "Hospital confined", give Name and Address of Hospital<br>Hospital Name Street Address City State Zip |
|---|---|

Confined From _____ Through _____

| Have you ever had the same or similar condition in the past? ☐ Yes ☐ No<br>If "Yes", when?<br>_____ | Treated By:<br>Hospital Name | Street Address | City | State | Zip |
|---|---|---|---|---|---|
| | Doctor Name | Street Address | City | State | Zip |

Information about your training, education, and experience
Please attach a copy of your resume, if applicable.

What is your level of education?
☐ Grade School ☐ High School ☐ Trade School ☐ College

☐ Other course *(please specify)* _____

List all previous occupations and the dates worked for each employer.

| **Employer's name** | **Dates of employment** | **Occupation/type of work** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

| **Yes** | **No** | **Type** | **Amount** | **Date Began** | **Date Term.** | **Paid Weekly** | **Paid Monthly** |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Sick Pay | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Salary Continuance | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Workers' Compensation | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Local, State or National Association or Society Disability Income Plan | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | No Fault | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Unemployment Compensation disability | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Social Security Benefits *(disability or retirement)* | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Retirement income *(normal, early, or disability)* | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Other STD/LTD Benefits | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Other *(describe)*_____ | $ _____ | _____ | _____ | ☐ | ☐ |

Have you applied, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type _____ Date Application filed _____

Type _____ Date Application filed _____

**I CERTIFY THAT THE ANSWERS I HAVE MADE TO THE ABOVE QUESTIONS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ THE FRAUD NOTICE ON PAGE 3 OF THIS FORM.**

**New York 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 shall also be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

_____ _____
Signature of Employee Date

Employee Name: _____
Employer Name: _____
Group Number: _____

## FRAUD NOTICE

**Unless specific state language is provided below, the following general fraud notice applies:** 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.

**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, Louisiana, New Mexico, 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.

**California –** 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."

**Delaware, Florida, Idaho, Indiana, Oklahoma –** 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, Colorado –** 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.

**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.

**Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

**Maryland, Alabama, Rhode Island and Texas –** 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 RSA 638:20.

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

**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.

**New York –** 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 stated value of the claim for each such violation.

Employee Name: _____
Employer Name: _____
Group Number: _____

**AUTHORIZATION FOR RELEASE OF INFORMATION**
**(excluding psychotherapy notes) (HIPAA Compliant) (to be signed and dated by the insured/claimant)**

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, a Family Medical Leave Act (FMLA) vendor, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Aflac *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and ***HIV/AIDS**** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by Aflac and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity,(b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, (c) an FMLA vendor that may assist me in filing an FMLA claim, and (d) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Aflac may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying Aflac in writing, of my revocation. However, such revocation is not effective to the extent Aflac has relied previously upon this authorization for the use or disclosure of my protected health information. I understand Aflac cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Aflac's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

* If you reside in ***California*****:** this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

* If you reside in ***Connecticut, Maine, or Massachusetts:*** this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

* If you reside in ***Vermont***: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Aflac to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Aflac shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

_____ _____
Claimant Name Date of Birth

_____ _____
Claimant Signature (or Authorized Representative) Date

Description of Personal Representative's Authority (If applicable):
(If signed by authorized representative, attach verification of identity)

Aflac

Employee Name: _____
Employer Name: _____
Group Number: _____

**Fax 1 (866) 376-9480**
**Toll Free Phone 1 (888) 862-5732**

**NOTICE OF CLAIM FOR LIFE WAIVER OF PREMIUM BENEFITS**

**EMPLOYER'S OR ADMINISTRATOR'S STATEMENT** **(All questions must be answered to avoid delay)**

| Name of Employee | | | Occupation | Is Disability due to employment? ☐ Yes ☐ No |
|---|---|---|---|---|
| Date employed / / | Date insured / / | Date last worked / / | Reason for stopping work ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ FMLA ☐ Other LOA ☐ Other _____ | |

| Date returned to work / / ☐ Full-Time ☐ Part-Time | If Part-Time, number of hours worked per week | If employee has not returned to work, estimated return to work date / / | Date employment terminated / / | Date disability insurance terminated / / |
|---|---|---|---|---|

| Required number of hrs. per week _____hrs. | Gross Annual Salary: *(During the 12 months just prior to your employee's disability)* $ _____ | Please indicate how the employee is paid *(check all that apply)*: ☐ Hourly ☐ Hourly Rate:_____ ☐ Salaried ☐ Other_____ ☐ Includes Commissions or Bonuses ☐ Includes Overtime Pay |
|---|---|---|

Employee eligible for:

| Yes | No | Type | Amount | Date Began | Date Term. | Paid Weekly | Paid Monthly |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Sick Pay | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Salary Continuance Benefits | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Workers' Compensation | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Local, State or National Association or Society Disability Income Plan | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | No Fault | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Unemployment Compensation disability | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Social Security Benefits *(disability or retirement)* | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Retirement income *(normal, early, or disability)* | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Other STD/LTD Benefits | $ _____ | _____ | _____ | ☐ | ☐ |
| ☐ | ☐ | Other *(describe)*_____ | $ _____ | _____ | _____ | ☐ | ☐ |

Please attach a copy of the following documents to this form:
- The employee's Workers' Compensation claim(s) and Approval/Denial Notification if applicable
- The employee's current job description

**I CERTIFY THAT THE ANSWERS I HAVE MADE TO THE ABOVE QUESTIONS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ THE FRAUD NOTICE ON PAGE 3 OF THIS FORM.**

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_____ _____
SIGNATURE DATE

| NAME OF POLICYHOLDER *(COMPANY) AND POLICY NUMBER* | PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE |
|---|---|
| MAILING ADDRESS OF POLICYHOLDER *(COMPANY)* CITY STATE ZIP | |
| TELEPHONE NUMBER / EXT | FAX NUMBER / EMAIL ADDRESS |

**PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE**

Aflac

Employee Name: _____
Employer Name: _____
Group Number: _____

**Fax 1 (866) 376-9480**
**Toll Free Phone 1 (888) 862-5732**

**NOTICE OF CLAIM FOR LIFE WAIVER OF PREMIUM BENEFITS**

## ATTENDING PHYSICIAN'S STATEMENT

**This statement must be filled-in completely by a physician without expense to insurance company.**

**(Please Print or Type)**

| Name of Patient (first, middle, last) | | | Gender ☐ M ☐ F | Date of Birth / / |
|---|---|---|---|---|
| Height | Weight | Blood Pressure (last visit) Systolic _____/ Diastolic _____ | | ☐ Left-handed ☐ Right-handed |

### 1. HISTORY

a. Is condition due to ☐ Accident? ☐ Sickness?
b. When did symptoms first appear or injury occur? Mo._____ Day _____ Year _____
c. Date patient was unable to work because of impairment Mo._____ Day _____ Year _____
d. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe: _____
_____
_____
e. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Please explain: _____
_____
f. Was this patient referred to you? ☐ Yes ☐ No If "Yes", by whom and what is their specialty? _____
_____
g. Have you referred this patient to another treating provider? ☐ Yes ☐ No If "Yes", to whom and what is their specialty?
_____

### 2. DIAGNOSIS

a. Diagnosis impacting function: _____ Diagnosis Code(s)_____
_____
Nature of treatment (including surgery with procedure code(s) and medications prescribed, if any, including dosage and frequency)
_____
_____
b. Secondary diagnosis impacting function:_____ Diagnosis Code(s)_____
_____
Nature of treatment (including surgery with procedure code(s) and medications prescribed, if any, including dosage and frequency).
_____
_____
c. Subjective symptoms: _____
_____
d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings):_____
_____
_____

### 3. DATES OF TREATMENT FOR THIS CONDITION

a. Date of first visit Mo._____ Day _____ Year _____
b. Date of last visit Mo._____ Day _____ Year _____
c. Next office visit Mo._____ Day _____ Year _____
d. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____
_____

### 4. PROGRESS

a. Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
b. Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
If "Hospital Confined", give Name and Address of Hospital _____
Confined from _____ through _____

### 5. CARDIAC (if applicable)

Functional Capacity (American Heart Assoc. standards) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

## 6. CURRENT FUNCTIONAL ABILITY

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

| | |
|---|---|
| ____ Hrs. Sedentary Activity | 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours. |
| ____ Hrs. Light Activity | 20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours. |
| ____ Hrs. Medium Activity | 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing. |
| ____ Hrs. Heavy Activity | 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing. |

b. Please check appropriate box:

| | Occasionally (0% to 33%) | Frequently (33% to 66%) | Continuously (66% to 100%) |
|---|---|---|---|
| Bending | ☐ | ☐ | ☐ |
| Climbing | ☐ | ☐ | ☐ |
| Reaching | ☐ | ☐ | ☐ |
| Kneeling | ☐ | ☐ | ☐ |
| Squatting | ☐ | ☐ | ☐ |
| Crawling | ☐ | ☐ | ☐ |
| Push/pull | ☐ No. of lbs._____ | ☐ No. of lbs._____ | ☐ No. of lbs._____ |
| Lifting (lbs.) | ☐ No. of lbs._____ | ☐ No. of lbs._____ | ☐ No. of lbs._____ |

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific._____

_____

d. Upper Extremity Function - Please indicate upper extremity functional capabilities:

| | | | |
|---|---|---|---|
| Simple grasp | ☐ Left | ☐ Right | Comments _____ |
| Pinch | ☐ Left | ☐ Right | Comments _____ |
| Fine manipulation | ☐ Left | ☐ Right | Comments _____ |
| Power grip | ☐ Left | ☐ Right | Comments _____ |
| Repetitive motion | ☐ Left | ☐ Right | Comments _____ |

## 7. MENTAL HEALTH ABILITY (if applicable)

☐ Patient is able to function under stress and engage in interpersonal relations (no limitation)
☐ Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
☐ Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
☐ Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
☐ Patient has significant loss of psychological, physiological, personal, and social adjustments (severe limitation)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

_____

_____

## 8. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b. Is this Patient motivated to return to his/her usual work or any work for which they are suited? ☐ Yes ☐ No
If "No", please explain_____

c. The date you released patient to return to work: _____/_____/_____ ☐ Full-time ☐ Reduced hours Number of hours: _____
Mo Day Year

d. Please identify your recommendations for any job modifications that would enable the patient to work. _____

_____

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_____ _____
**ATTENDING PHYSICIAN'S SIGNATURE** DATE

| PHYSICIAN'S NAME (PLEASE PRINT) | DEGREE/SPECIALTY | |
|---|---|---|
| TELEPHONE NUMBER | FAX NUMBER | TAX ID # |
| OFFICE ADDRESS | CITY | STATE ZIP |

**PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE**