



Liberty Life Assurance Company of Boston

EMPLOYER'S STATEMENT

Group Market Disability Claims
 Liberty Life Assurance
 Company of Boston
 P.O. Box 7207
 London, KY 40742-7207
 Fax # (603) 334-0380

TO BE COMPLETED BY EMPLOYER

Employee's Name, Address & Phone No.				Employee's Social Security No.		
Location/Branch at Which Employee Works			Location/Branch Telephone No. () Ext.			
Employee's Ben% STD _____ LTD _____		Policy No.	Effective Date of Policy		Employee's Date of Birth	
Employee's Date of Hire		Employee's Effective Date of Insurance STD _____ LTD _____				
Percentage of STD Premium Contribution Employee Pays _____% Employer Pays _____%			Percentage of LTD Premium Contribution Employee Pays _____% Employer Pays _____%			
Date Employee Last Worked			Date Employee Returned to Work Full-time _____ Part-time _____			
Reason for Stopping Work <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Resigned <input type="checkbox"/> Terminated <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Granted LOA <input type="checkbox"/> Vacation <input type="checkbox"/> Other						
Is condition due to an occupational cause? If "Yes", please indicate status of Workers' Compensation claim. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Accepted <input type="checkbox"/> Pending <input type="checkbox"/> Denied <input type="checkbox"/> Not Filed Note: please attach a copy or Workers' Compensation claim and Approval/Denial Notification, if applicable.						
Work Schedule at Time Last Worked Days per Week _____ Hours per Day _____			How is employee paid? <input type="checkbox"/> Salary <input type="checkbox"/> Salary & Commissions <input type="checkbox"/> Bonuses <input type="checkbox"/> Hourly <input type="checkbox"/> Commissions only			
Earnings (excluding commissions and bonuses) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly			Occupation (please attach Job Description) Lifting Requirements: Max lbs. _____ Min lbs. _____ Percentage of Day: Sitting _____% Standing _____% Walking _____%			
Has or will this employee receive any of the following for the entire or a portion of the absence covered by this claim?						
Yes	No	Type	Amount per Week/Month	Date Began Receiving	Date Ceased Receiving	Date Income Applied For
<input type="checkbox"/>	<input type="checkbox"/>	Wages, Salary, or Holiday Pay	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vacation	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sick Leave	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Separation Pay	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Disability Pension	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Pension	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation (this condition)	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	LTD, STD benefits	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe) _____	\$ _____	_____	_____	_____
Employer's Name & Address						
Employer's Telephone No. () Ext.			Employer's Fax No. ()			
Workers' Compensation Carrier		Street Address		City	State	Zip Code
Workers' Compensation Carrier Contact's Name			Workers' Compensation Carrier Contact's Telephone No.			
Employer (Taxpayer) ID No. (EIN) or Public Employer Social Security No.						
Printed Name and Title of Person Completing this form			Telephone No. of Person Completing this form () Ext.			
Signature of Person Completing this form			Date Signed			

ATTENDING PHYSICIAN'S STATEMENT

**This form is to be completed
without expense to Liberty Mutual and returned
along with your original claim for benefits or
by the date requested by the Liberty Mutual Claims Dept.**



Group Market Disability Claims
Liberty Life Assurance
Company of Boston
P.O. Box 7207
London, KY 40742-7207
Fax # (603) 334-0380

Return to: _____

EMPLOYEE/CLAIMANT NAME: _____	
CLAIM NO.: _____	S.S. NO.: _____ - _____ - _____
EMPLOYER/SPONSOR: _____	DATE OF BIRTH: _____

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder for purposes of auditing Liberty's administration of claims under the policy, and persons or organizations providing medical treatment or services in connection with my claim.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This authorization shall become effective on the date appearing next to my signature below.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this authorization at any time by written notification to the Plan Sponsor and/or the Company in the Liberty Mutual group of companies to which I submit a claim.

Date	Claimant's Signature (or Authorized Representative)
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PHYSICIAN'S INSTRUCTIONS

PLEASE NOTE: IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.

THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.

1. DIAGNOSIS		
Primary _____	ICD9 _____	
Secondary _____	ICD9 _____	
_____	ICD9 _____	
Has patient ever had the same or a similar condition? Yes _____ No _____		
If "Yes", state when and describe. _____		
What is your prognosis? _____		
For Pregnancy:		
EDC _____	Date of Delivery _____	Type _____
2. DATES OF TREATMENT		
(a) Date of First Visit _____		(mo/day/yr)
(b) Date of Last Visit _____		(mo/day/yr)
(c) Frequency of Visits _____	Weekly _____ Monthly _____	Other (specify)
(d) Date of First Treatment _____		(mo/day/yr)
(e) Date Symptoms First Appeared / Accident Occurred _____		(mo/day/yr)
(f) Date Patient Advised to Cease Work _____		
(g) Estimated Return to Work Date _____		

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PART A: TO BE COMPLETED BY EMPLOYEE

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

3. Please describe in detail your PROPOSED TREATMENT PLAN. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan. IDENTIFY ANY RESTRICTIONS you have imposed on your patient at this time.

4. PHYSICAL IMPAIRMENT

- Class 1 - No limitation of functional capacity; capable of heavy work.
- Class 2 - Medium manual activity.
- Class 3 - Slight limitation of functional capacity; capable of light work.
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative activity.
- Class 5 - Severe limitation of functional capacity; incapable of minimum activity.

REMARKS:

5. MENTAL/NERVOUS IMPAIRMENT

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2 - Patient is able to function in most stressful situations and engage in most interpersonal relations (slight limitations).
- Class 3 - Patient is able to engage in only limited stressful situations and engage only in limited interpersonal relations (moderate limitations).
- Class 4 - Patient is unable to engage in stressful situations or engage in interpersonal relations (marked limitations).
- Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations).

REMARKS:

6. CARDIAC IMPAIRMENT (if applicable)

Functional Capacity: Class 1: No Limitation Class 2: Slight Limitation
 (per American Heart Assn) Class 3: Marked Limitation Class 4: Complete Limitation

Blood Pressure (last visit): _____
(systolic/diastolic)

7. Date of Next Scheduled Visit

Are you still treating the patient? Yes No
 If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician? Yes No

8. Has patient been hospital confined? Yes No

Dates of Confinement: From _____ to _____
 Was surgery performed? Yes No If "Yes", please indicate procedure(s) performed:
 CPT Code: _____ Date Performed _____
 Name and Address of Hospital: _____

9. After you have completed this form, please attach copies of the following materials:

- Office notes for the period of treatment or for the last two years
- Test results showing objective findings
- Hospital discharge summary (if applicable)
- Consulting physician's reports (if applicable)

10. REMARKS

Attending Physician's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID No.
Street Address	() Telephone No.	() Fax No.
City/State/Zip Code	Signature	Date



DISABILITY CLAIM FORM

Liberty Life Assurance Company of Boston

PLEASE CHECK STD

BENEFITS

APPLIED FOR: LTD

Group Market Disability Claims
Liberty Life Assurance
Company of Boston
P.O. Box 7207
London, KY 40742-7207
Fax # (603) 334-0380

TO BE COMPLETED BY EMPLOYEE (PLEASE COMPLETE ALL APPLICABLE SPACES)

Employee's Name		Employee's Social Security No.				
Street Address		City	State Zip Code			
Home Telephone No. () ()	Work Telephone No. () ()	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth			
Employer's Name	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Spouse's Name	Spouse's Date of Birth			
Please List Names and Dates of Birth of No. of Children under 19						
Treated By: (Please include all treating physicians; use additional paper if needed)						
HOSPITAL						
Name		Street Address	City/State/Zip Code			
DOCTOR(S) Name:	Name:	Name:	Name:			
Address:	Address:	Address:	Address:			
Phone:	Phone:	Phone:	Phone:			
Date Injury/Illness Began	Date First Treated	Date Last Worked	Date Returned to Work			
Have you or do you intend to file a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", then please explain:						
Describe how and where injury occurred or describe the onset and nature of your illness. If maternity please include delivery date or expected delivery date.						
Identify other income you are receiving or for which you have applied:						
Yes	No	Type	Amount per Week/Month	Date Began Receiving	Date Ceased Receiving	Date Income Applied for
<input type="checkbox"/>	<input type="checkbox"/>	Wages, Salary, or Separation Pay	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security (disability or retirement)	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	State Disability	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Retirement (normal, early, or disability)	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Group Disability	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	No Fault Income	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe) _____	\$ _____	_____	_____	_____
If your request for disability benefits is approved, all or a part of your benefits may be considered taxable income if they are attributable to: 1) employer contributions toward the disability plan or, 2) your contributions, on a pre tax basis, toward the disability plan.						
Apply a <u>voluntary federal income tax</u> withholding to each benefit payment? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", select <u>one</u> of the following:						
<input type="checkbox"/> Withhold a percentage of the disability benefit subject to federal taxation. _____% (whole % only, minimum of 10%), <u>or</u>						
<input type="checkbox"/> Withhold a specific whole dollar amount based upon the disability payment mode (weekly, bi-weekly, semi-monthly, monthly), <u>or</u>						
\$ _____ weekly (\$20.00 min.) \$ _____ bi-weekly (\$40.00 min.) \$ _____ semi-monthly (\$44.00 min.) \$ _____ monthly (\$88.00 min.)						
<input type="checkbox"/> Use the completed and signed IRS Form W-4S I have attached which specifies my withholding request.						
Apply a <u>voluntary state income tax</u> withholding to each benefit payment? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", select <u>one</u> of the following:						
<input type="checkbox"/> Withhold \$ _____ (\$10.00 minimum) for the State of _____, <u>or</u>						
<input type="checkbox"/> Use the completed and signed state employee withholding certificate I have attached which specifies my withholding request.						
Signature: _____			Date: _____			

PLEASE READ CAREFULLY, SIGN AND DATE BELOW

The information I have provided is true and complete to the best of my knowledge and belief. I agree that a Photostat copy of this form will be as valid as the original. I understand that any person who knowingly or with intent to injure, defraud, or deceive an insurance company, files a statement containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

CALIFORNIA EMPLOYEES: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO EMPLOYEES: 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 EMPLOYEES: It shall be a fraudulent insurance act for a person to knowingly, by act or omission, with intent to injure, defraud or deceive: prepare, present or cause to be presented to any insurer, any oral or written statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, containing false, incomplete or misleading information concerning any fact material to such claims.

FLORIDA EMPLOYEES: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement or claim or an application containing any false, incomplete, or misleading information is guilty of a felony of third degree.

KENTUCKY EMPLOYEES: I understand that 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MINNESOTA EMPLOYEES: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

NEW YORK EMPLOYEES: 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 and the stated value of the claim for each such violation.

NORTH CAROLINA EMPLOYEES: Any person who with the intent to injure, defraud, or deceive an insurer or insurance claimant: presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or assists, abets, solicits or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning fact or matter material to the claim is guilty of a felony.

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

PENNSYLVANIA EMPLOYEES: 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.

EMPLOYEE SIGNATURE: _____ **DATE SIGNED:** _____