INDIVIDUAL DISABILITY NOTICE OF CLAIM

Please check the box next to your insurance company's name.
❑ Central United Life ❑ Investors Consolidated ❑ Sun America ❑ Loyal
❑ Gold Cross ❑ UniLife ❑ Unum ❑ American States

We cannot process your claim without a completed form.

1. Complete Part I of this form.
2. Have your employer complete Part II of the form.
3. Have your attending physician complete Part III of the form.
4. When all sections of this form have been completed, submit the form to the address below.
5. If you have any questions, call us at: 1-800-669-9030.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____Social Security Number _____

Date of Birth_____ Policy Number _____

I,_____, hereby authorize _____'s designated medical custodians or database custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the person(s) or organization(s):

Name of Person(s) or Organization(s):

_____
(Company Name)
P.O. Box 925309
Houston, TX 77292-5309

I specifically authorize the use and disclosure of the following PHI:_____
_____
_____
_____
(Specifically describe the protected health information to be disclosed. Include meaningful descriptors such as date of service, type of service provided, level of detail to be released, etc.)

This protected health information is being used or disclosed to carry out treatment, payment, and/or the _____'s internal operations in the following manner:_____
_____
_____
(Specifically describe how protected health information will be used to carry out treatment, payment, or the company's internal operations purposes.)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand and agree that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notice to the company. A revocation is not effective except to the extent that the company has relied on the use or disclosure of the PHI (protected health information).
- l Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The company will not condition my treatment, payment, and enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
- I have the right to refuse to sign this authorization form.

_____
Signature Date Description of Personal Representative's Authority

NO FAXED OR COPIED CLAIMS ACCEPTED
Submit Completed Form to:
Claims Department, P.O. Box 925309, Houston, TX 77292-5309
Customer Service Department 1-800-669-9030

MANHATTAN INSURANCE GROUP

INDIVIDUAL DISABILITY CLAIM FORM

Name of Insured	Policy Number	Date of Birth	Home Telephone

Home Address (Street, City, State, Zip) ❑ Please Check if this is a change of address

Name of Employer	Business Telephone	Social Security Number

Business Address	Monthly Gross Earned Income $

Please check any and all benefits that you are eligible to receive:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Policy No.	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date
A. Social Security	❑	❑	❑	❑					
B. State Disability Insurance	❑	❑	❑	❑					
C. Retirement or Pension	❑	❑	❑	❑					
D. Short Term Disability	❑	❑	❑	❑					
E. Salary Continuation	❑	❑	❑	❑					
F. Unemployment	❑	❑	❑	❑					
G. Worker's Compensation	❑	❑	❑	❑					

Date of your accident or the date you first noticed the symptoms of your illness:	Date you last worked:	I returned to work on a part-time basis on:	I returned to work on a full time basis on:
_____ Month Day Year	_____ Month Day Year	_____ Month Day Year Have not returned yet ❑	_____ Month Day Year Have not returned yet ❑

Describe your disability and its cause. If accidental, please provide complete accident details including how, where, when, etc.

Are you covered by Workers Compensation for this disability? ❑Yes ❑No

List all physicians or other practitioners consulted for this condition. (Use additional pages if needed.)

Name	Address	Dates Consulted

List ALL physicians or practitioners consulted FOR ALL CONDITIONS in the past five (5) years. (Use additional pages if needed.)

Name	Address	Dates Consulted/Reason for Consultation

List ALL hospital confinements FOR ALL CONDITIONS in the past five (5) years. (Use additional pages if needed.)

Name	Address	From	To	Reason Confined

The Statements in this form are true and complete to the best of my knowledge.

_____ Signature (Insured)

_____ Date

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Customer Service Department 1-800-669-9030

MANHATTAN INSURANCE GROUP

OCCUPATIONAL INFORMATION

TO BE COMPLETED BY THE INSURED

What was your occupation immediately prior to the date you became disabled?

List all duties of the occupation noted above. (Failure to be specific may result in a delay in the processing of your claim.)

Description of Each Duty	Weekly % of Time Devoted to this Activity	Weekly Hours Spent at this Activity

Describe briefly which of these duties you are unable to perform as a result of your sickness or accident, and why.

Describe briefly your prior work experience and education.

TO BE COMPLETED BY THE EMPLOYER (if retired, by the former employer)

Employer Name	Employer's Telephone Number
Employer Address (street, city, state, ZIP code)	
Worker's Compensation Claim Filed? ❑ Yes ❑ No	Name of Compensation Carrier
Address, and Telephone Number of Compensation Carrier	
Between what dates did employee give up all duties due to TOTAL DISABILITY? From: To:	
Name of Previous Disability Insurer:	
Effective Date:	Term Date:
Date Title	Signature

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY; FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION; IS GUILTY OF A FELONY OF THIRD DEGREE.

The Statements in this form are true and complete to the best of my knowledge.

_____ _____

Signature (Insured) Date

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MANHATTAN INSURANCE GROUP

ATTENDING PHYSICIAN'S INITIAL REPORT

Please print all entries. This form is to be completed without expense to the company.

Name of Patient (last, first, middle initial)	Was patient referred by another physician? ❑Yes ❑No Name & Address:
DIAGNOSIS: (If psychiatric in origin, please indicate DSM III code and axis.)	
What limitations are there on your patient's ability to perform his or her job duties?	Date Restrictions Began (Mo. Day Year)
When do you expect that these limitations/restrictions will allow your patient to return to work?	
When were you first consulted for this condition? (Mo. Day Year)	How did this condition develop?
Any previous occurrences of this condition or similar conditions? If so, please provide dates and details:	
Dates of all other visits to your office:	Is patient currently being treated by any other practitioner or therapist? ❑Yes ❑No Name & Address:
How long was or will patient be Continuously **Totally Disabled**? **EXACT Start Date:** **TO:**	How long was or will patient be **Partially Disabled**? **EXACT Start Date:** **TO:**
Name and address of hospitals and dates of confinement:	
Describe past treatment for this condition, including any surgical procedures:	
Describe course of treatment to be followed; including surgery:	Is patient still under your care? ❑Yes ❑No If "No," please explain
Please list other disability insurers to whom you are providing information on this patient.	
Does your patient have any chronic or recurring condition(s) not noted above? ❑Yes ❑No Please provide details:	
Remarks or Additional Comments:	

Name of Attending Physician (please print)	Degree Code	Telephone Number
Address (Street or P.O. Box, City, State, Zip)		Tax Payer I.D. Number
Signature of Physician		Date

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MANHATTAN INSURANCE GROUP

Claim Form Addendum: Fraud Warning and State Versions

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alaska A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **Arkansas** 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. **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. **California** For your protection California law requires the following to appear on this form. Any person who knowingly presents 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** 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** 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** 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** 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. **Hawaii** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. **Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **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. **Louisiana** 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. **Maine** 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** 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. **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. **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 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 the stated value of the claim for each such violation. **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. **Oklahoma** 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. **Oregon** 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. **Pennsylvania** 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. **Puerto Rico** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. **Tennessee** 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. **Virginia** 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. **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 include imprisonment, fines, and denial of insurance benefits. **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.