DisabilityRMS PO Box 9757
Portland, ME 04104

LifeMap Assurance Company®

Claims Department
Toll Free: 1 (877) 254-0085
Fax: (207) 591-3048

LifeMapCo.com

Statement for Extended Life Insurance for Spouse Voluntary Life

Claim Filing Instructions

This Statement for Extended Life Insurance for Spouse Voluntary Life includes the forms required to apply for continuation of voluntary life insurance coverage without payment of premium for an Employee's Spouse during the spouse's total disability.

If a form is received incomplete, unsigned or undated, it will be returned to you for completion.

Have you, the Spouse…

1. completed in full, signed and dated the Spouse's Statement?
2. as the claimant, signed and dated the Authorization for Release of Information?
3. had the physician treating you as a patient, complete, sign and date the Attending Physician's Statement, and had it returned to you?

Have you, the Employee….

1. had your Employer complete, sign and date the Employer's or Administrator's Statement, and had it returned to you and/or your Spouse?

The Spouse applying for Extended Life Insurance is responsible for ensuring all forms are completed and returned to our office.

Forms can be sent via:

Email: **claims@yourbenefitexpert.com**

Fax: **(207) 591-3048**

Regular Mail: **LifeMap Claims - DisabilityRMS**
PO Box 9757
Portland, ME 04104

If you have any questions, please call us at 1 (877) 254-0085.

Please note, you, the Spouse must notify us promptly if:

- Your medical condition improves so that you would be able to work, even though you have not yet returned to work.
- You go to work in any capacity for any employer, or as a self-employed person.

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Spouse's Statement

Spouse Information

Spouse Name			Social Security Number
Mailing Address (Street & Number, City, State, Zip)			
Home Phone Number ( )	Cell Phone Number ( )	Date of Birth	☐ Male ☐ Female

Employee Information

Employee Name			Social Security Number
Mailing Address (if different from Spouse) Street & Number, City, State, Zip			
Home Phone Number ( )	Cell Phone Number ( )		Date of Birth
Employer Name	Employer Phone Number ( )		LifeMap Policy Number

Spouse Employment Information

Employer Name	Employer Phone Number ( )	
Employer's Mailing Address (Street & Number. City, State, Zip)		
Your Occupation & Title		
List essential duties of your job at the time of disability*: ***Please attach a detailed job description from your current Employer**		
Date Employed:	Date Last Worked:	Date of Termination: ☐ N/A
How many hours were you regularly working per week with your present employer?		
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 _____		

Please complete the following page.

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Spouse's Statement (continued)

Spouse Medical Information

Date first treated for this condition:	First date unable to work because of disability:
Date of injury or date first noticed symptoms of illness:	Have you ever had the same or similar condition in the past? ☐ No ☐ Yes, when?
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.):	
Are you now totally disabled and unable to work? ☐ Yes ☐ No	
Briefly state your present daily activities:	

Attending Physician (Attach a separate piece of paper if additional space is needed.)

Physician Name:	Phone Number ( )
Street Address City State Zip	Fax Number ( )
Condition(s)	Period of Treatment:

Physician Name:	Phone Number ( )
Street Address City State Zip	Fax Number ( )
Condition(s)	Period of Treatment:

Education, Training and Experience

List any skills which you may have as a result of prior employment, training, education, or military service:
List last year of school completed (e.g., 6th Grade, 12th Grade, College Degree, etc.):

Acknowledgement

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 4 of this form.

▶ _____ ▶ _____

Spouse's Signature Date

Complete Authorization to Obtain and Release of Information form on page 5.

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Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: 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.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: 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.

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

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 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.

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Delaware, Idaho, Indiana and Oklahoma Residents: 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.

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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, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, 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, Workers Compensation, State Disability, pension, credit, earnings and employment history), to give any and all such information to authorized representatives of LifeMap Assurance Company, *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital 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 that the information obtained by use of this authorization will be used by LifeMap Assurance Company 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, or (b) any other organization or person, employed by or representing LifeMap Assurance Company to assist with the evaluation and adjudication of my current disability claim and/or to report aggregate claims information to LifeMap Assurance Company. I understand that 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, or any other federal or state law.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that 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 that I have the right to revoke this authorization by notifying LifeMap Assurance Company in writing, of my revocation. However, such revocation is not effective to the extent that LifeMap Assurance Company has relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair LifeMap Assurance Company's ability to evaluate my current disability claim and as a result 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). 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 **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 LifeMap Assurance Company 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 LifeMap Assurance Company shall comply, as applicable, with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Signature (or Authorized Representative) _____ Date: _____

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

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Employer's or Administrator's Statement

(to be completed by the Group Policyholder/Employer with LifeMap coverage)

Information about Employee insured under LifeMap coverage

Employee Name	Date Employed:
Job Title:	Class:
Employee's Earnings: $ Regular scheduled hours per week:	If coverage is under a union or trustee plan. Date insured became a member:
Earnings prior to increase: $ Date of last increase:	
☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ shift differential ☐ bonuses ☐ other:	Date the insured terminated membership:

Information about Employee's Spouse Life Insurance Coverage

Spouse Life Insurance coverage: Effective Date: Termination Date:	Amount of **Spouse** Insurance: Voluntary Life:

Information about Employee's Life Insurance Coverage

Employee Life Insurance coverage: Effective Date: Termination Date:	Amount of **Employee** Insurance: Basic Life: $ Dependent's Life: $ Voluntary Life: $

Information about Employer with LifeMap Group coverage

Employer Name	Location Code (if applicable)	LifeMap Policy Number
Employer Address Street & Number	City	State Zip
Phone Number ( )	Email Address	
Name and Title of Employer Representative completing this form:		

Acknowledgement

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 7 of this form.

▶ _____ _____

Employer Representative's Signature Date

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Hawaii Residents: 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.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: 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.

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

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 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.

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Attending Physician's Statement

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

Patient Information

Full Name of Patient		Social Security Number
Height	Weight	Blood Pressure / Date Taken

Information about Diagnosis

Diagnosis	ICD Code(s)
Symptoms	
Concurrent Conditions	
Objective findings (including current X-rays, EKGs, laboratory data and any clinical findings)	
Date symptoms first appeared or injury occurred:	Date you recommended the patient stop working:
Patient's condition is due to: ☐ Illness ☐ Accident	Has patient ever had the same or a similar condition? ☐ Yes ☐ No If Yes, when
Is condition arising out of patient's employment? ☐ Yes ☐ No	Did you complete Workers' Compensation claim form? ☐ Yes ☐ No

Information about Treatment

Date of first visit for this condition:	Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____	Next office visit:
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)		

Hospital Admission Date:	Hospital Discharge Date:	Was Surgery Performed? ☐ Yes ☐ No	Date of Surgery:
Name of Procedure:		Surgery/Post-Operative Complications: ☐ Yes ☐ No If yes, please describe:	
Was patient treated by another provider(s) for this disability? ☐ Yes ☐ No If Yes, please provide dates, name and address of provider(s):			

For Pregnancy Disability Only

Date of Last Menstrual Period	Expected Date of Delivery	Actual Date of Delivery	☐ Vaginal ☐ C-Section
Are there any present complications or anticipated difficulties: Pregnancy ☐ Yes ☐ No Delivery ☐ Yes ☐ No Post Partum ☐ Yes ☐ No If "Yes" to any of these, please describe in detail:			

Please complete the following page.

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Attending Physician's Statement (continued)

Full Name of Patient

Assessment of Physical Impairment (as defined in the Federal Dictionary of Occupational Titles)

☐ Class 1 - No Limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
☐ Class 2 - Medium manual activity* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capability; capable of clerical/administrative (sedentary) activity* (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)

Assessment of Mental Impairment (if applicable)

☐ Class 1 - Patient able to function under stress and able to engage in interpersonal relations (No limitations).
☐ Class 2 - Patient able to function in most stress situations and engage in limited interpersonal relations (Slight limitation).
☐ Class 3 - Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation).
☐ Class 4 - Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation).
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation).

Assessment of Current Functional Ability

Describe current restrictions (activities which should not be performed by the patient):
Describe current limitations (activities which cannot be performed by the patient):
Related to a mental health condition, describe behaviors, attitudes or functional impairments that are contributing to the patient's restrictions and/or limitations:
Describe factors delaying recovery (if applicable): ☐ Malingering ☐ Exaggeration ☐ Other (specify):
Is the patient competent to manage insurance benefits? ☐ Yes ☐ No If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

Return to Work Plan

Date you released patient to return to work:	☐ Full Time ☐ Modified Duties ☐ Any Occupation	☐ Own Occupation ☐ Part Time ☐ Reduced Hours	Number of hours per week:
How long do you expect these limitations and restrictions to impair your patient? ☐ Date: ☐ Unable to determine, follow up appointment: ☐ Permanently			
Please identify your recommendations for any job modifications that would enable the patient to work:			

Information about Physician

Physician's Name (Please Print)	Degree/Specialty			Phone No. ( )
Office Address	City	State	Zip	Fax No. ( )

Acknowledgement

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 10 of this form.

▶ _____ ▶ _____

Attending Physician's Signature Date

Please return completed form to your patient.

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