GROUP DISABILITY CLAIM FORM

Sentry Life Insurance Company
P.O. Box 8029
Stevens Point, Wisconsin 54481-8029
800-272-0533
disabilitylifeclaims@sentry.com

TO BE COMPLETED BY EMPLOYER: THIS PORTION MUST BE COMPLETED BEFORE CLAIM CAN BE PROCESSED

DATE EMPLOYEE HIRED: ___________________ HAS EMPLOYEE'S **EMPLOYMENT** TERMINATED? ☐ YES ☐ NO **IF YES, GIVE DATE:** _______________

WAS EMPLOYEE WORKING FULL TIME PRIOR TO CLAIM? ☐ YES ☐ NO **IF YES, GIVE NUMBER OF HOURS WORKED PER WEEK:** _____________________

DATE INJURED: ______________________ DID ILLNESS OR INJURY OCCUR IN THE COURSE OF EMPLOYMENT? ☐ YES ☐ NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO **IF YES, GIVE DATE:** ___________________________

% Group Disability Income Insurance premium paid by: Employer _______% Employee – Pre-tax _______% Post-tax _______% = 100%

These figures should represent the average of the contributions of the last three policy years prior to the year of date of loss.

LAST DAY WORKED:	OCCUPATION:	HOURLY RATE OF PAY:	HOURS PER WEEK:	REGULAR WEEKLY WAGE:	SALARIED EMPLOYEE: YES ☐ NO ☐

HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO **IF YES, GIVE DATE**: _________________________

THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THIS EMPLOYEE'S GROUP DISABILITY INCOME INSURANCE.

EMPLOYER: ____ BY: ____________________ TITLE: ___________________________

ADDRESS: ____ PHONE NUMBER: ( ) _______________ DATE: _______________
(STREET, CITY, STATE, ZIP CODE)

CLAIMANT STATEMENT – This statement must be completed by the employee. If the employee is mentally incompetent, the statement should be completed by the guardian or other legal representative, or if none has been appointed, by the beneficiary named in the policy. Include certified copy of appointment.

Your Full Name:	Date of Birth:	Telephone Number:

Residence Address (Number, Street, City, State):	Social Security Number:

Sex: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Number of Dependents:	Dependent(s) Date of Birth:

State the causes of your disability. If accident, describe when, where, and how accident occurred.

On what date were you first totally disabled by this sickness or injury (wholly unable to work)?	Date first treated by a physician:

List specific symptoms related to your disabling condition(s) which prevent you from working:

Have you returned to work? ☐ Yes ☐ No If "Yes," on what date: _______________ Part-time _______________ Full-time

If you have not returned to work, on what date do you expect to return to work? _______________ Part-time _______________ Full-time

Is employee covered by or now receiving benefits from the following?	Covered Yes	Covered No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Social Security	☐	☐	☐	☐	☐				
b. Workers' Compensation	☐	☐	☐	☐	☐				
c. State Disability Insurance	☐	☐	☐	☐	☐				
d. Retirement or Pension (Employer, PERS, STRS, PERA, etc.) ***Please specify*** __________________	☐	☐	☐	☐	☐				
e. Other __________________ (e.g., any wages, earnings, or benefits)	☐	☐	☐	☐	☐				
f. Unemployment Benefits	☐	☐	☐	☐	☐				

Are you insured with any other company? ☐ Yes ☐ No If so, please state the full names and addresses of the companies and the policy numbers.

Name all physicians who have treated you for your disabling condition(s):

NAME OF DOCTOR	ADDRESS	PHONE	TREATMENT PERIOD

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice below.

Signature ____ Date ____________________

Warning – Some states require the following to appear on claim forms:

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 (in some states a felony, and in Florida a felony of the third degree), and subject such person to criminal and civil penalties, and in some states imprisonment.

See Other Side For Physician's Statement

PHYSICIAN STATEMENT

TO BE COMPLETED BY TREATING PROVIDER

Sentry Life Insurance Company
P.O. Box 8029
Stevens Point, Wisconsin 54481-8029
800-272-0533
disabilitylife@sentry.com

Full name of the patient: ____________ Date of Birth: ________ Height: ________ Weight: ________
Are you the present treating physician? ☐ Yes ☐ No Date first consulted for this condition? ____________
Date of last treatment/exam? ____________ Total number of times seen? ____________

Primary and secondary diagnosis: ____________
Has your diagnosis been confirmed by (please check):
☐ Radiology ☐ Laboratory ☐ Psychological ☐ Other Tests: ____________ Date of Test(s): ________
If additional tests, please name them: ____________

What are the patient's subjective symptoms or complaints? ____________

Give the physical findings observed by you during your attendance: ____________

What past history was given to you? Please include date/onset of symptoms:

Name and addresses of any other treating physicians for the disabling condition(s):

Did you advise the patient to
a) reduce work hours? ☐ Yes ☐ No If yes, as of what date? ____ / ____ / ____
b) cease work? ☐ Yes ☐ No If yes, as of what date? ____ / ____ / ____
c) work light duty? ☐ Yes ☐ No If yes, as of what date? ____ / ____ / ____

1. Degree of Physical Impairment: In an 8-hour work day, your patient can:

Lift/carry (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+
Push/pull (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Total hours with positional changes

Sit	8	7	6	5	4	3	2	1	(hrs)
Stand	8	7	6	5	4	3	2	1	(hrs)
Walk	8	7	6	5	4	3	2	1	(hrs)
Alternatively sit/stand	8	7	6	5	4	3	2	1	(hrs)

Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently
Reach: ☐ Never ☐ Occasionally ☐ Frequently
Drive: ☐ Never ☐ Occasionally ☐ Frequently
Dominant Hand: ☐ Right ☐ Left
Other restrictions: ____________ Duration: ____________

Degree of Cardiac Functional Impairment: (check one)
☐ Class 1 (No limitation)
☐ Class 2 (Slight limitation)
☐ Class 3 (Marked limitation)
☐ Class 4 (Complete limitation)
EF ______ % Date ________

2. Degree of Psychiatric Impairment if applicable (check one):
☐ Inadequate information to make assessment
☐ Essentially good functioning in all areas. Occupationally and socially effective.
☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
☐ Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.
☐ Inability to function in almost all areas.
Current GAF (Global Assessment of Functioning): ________ /90 Highest GAF in past year: ________ /90
Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

3. Return to Work Expectation
In your opinion, does the patient have some capacity for work? ☐ Yes ☐ No
If yes, as of what date? ______ / ______ / ______ ☐ Full-time ______ / ______ / ______ ☐ Part-time
If no, when do you anticipate the patient will have capacity for work? ______ / ______ / ______
☐ Full-time ☐ Part-time ☐ Never

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Name of Physician: (Print)	Signature of Physician:	
Address: (Number and Street)	Physician Degree:	Specialty:
Phone Number: ( )	Fax Number: ( )	
City: State:	Zip:	Date Signed:

Please refer to the FRAUD WARNING that applies in your state.

AK, CA, CT, DE, GA, HI, IA, ID, IL, IN, MI, MN, MO, MS, MT, NE, NC, ND, NH, NM, NV, PA, SC, SD, TX, UT, WI, WV, WY

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance 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/or civil penalties.

AL

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

AR, LA, MA, RI

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.

AZ

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.

CO

It is unlawful to knowingly provide false, incomplete, or misleading material 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 material 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.

DC

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.

FL

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.

KS

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MD
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.

ME, TN, VA, WA
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.

NJ
Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY
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.

OH
Any person who, with intent to defraud or knowing that he/she 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.

OK
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.

OR
ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURANCE COMPANY, SUBMITS AN APPLICATION FOR INSURANCE OR FILES A CLAIM CONTAINING A MATERIALLY FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

PR
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 by 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 be 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.

VT
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 may be subject to criminal or civil penalties.