Application for Long Term Disability Benefits

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
100 Bright Meadow Boulevard
PO Box 1955
Enfield, CT 06083-1955

Must Be Completed in Full at No Expense to GE Group Life Assurance Company

Employee (Please Print)

1. Full Name (Last, First, M.I.)
Social Security Number
Phone Number ( )

2. Address (No., Street, City, State, ZIP Code)
3. Occupation (List the duties of your occupation at the time of disability.)

4. Date of Birth | Height | Weight | Sex ☐ Male ☐ Female | Marital Status | Spouse's First Name and Date of Birth | Is Spouse Employed? ☐ Yes ☐ No

5. Number of Children
Children's First Names & Dates of Birth

6. I have been unable to work because of this disability since: (Mo - Day - Yr)
I returned to work on a part-time basis on: (Mo - Day - Yr)
I returned to work on a full-time basis on: (Mo - Day - Yr)

7. Date of your accident or the date you first noticed the symptoms of your illness: (Mo - Day - Yr)
Is your accident or illness related to your occupation? ☐ Yes ☐ No
If yes, have you or do you intend to file for Workers' Compensation benefits? ☐ Yes ☐ No

8. Describe how and where accident occurred or describe the first symptoms of your illness:

9. Date you were first treated for your illness or injury: (Mo - Day - Yr)
Treated by
Hospital Name _____ Address _____
Doctor's Name _____ Address _____

10. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
If yes, when? (Mo - Day - Yr)
Treated by
Hospital Name _____ Address _____
Doctor's Name _____ Address _____

11. Describe any other income you are receiving or are eligible to receive as a result of your disability. (Examples: Social Security, Workers' Compensation, State Disability, Pension Disability/Retirement; etc.)

Describe Source	Amount of Income	(Wkly, Bi-wkly, Monthly)	Date App. Filed	Date Income Began	Date Income Ended

State law, in some states, requires the following statement: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a statement of Claim that contains any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. **VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.**

AUTHORIZATION TO OBTAIN AND REDISCLOSE INFORMATION

I hereby authorize any hospital, physician, pharmacy or other person, or any health care provider, Insurance Company, Plan Administrator, any Government Agency, Social Security Administration, any information gathering services such as MIB, Inc. or HCI to disclose or furnish to GE Group Life Assurance Company or its representatives, any and all information with respect to any injury or illness including mental illness, drug/alcohol abuse, HIV-related, AIDS or AIDS related information to the extent permitted by law, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to evaluate my claim. A photographic copy of this authorization shall be considered as effective and as valid as the original. This authorization is valid for the duration of the claim.

Signature of Employee _____ Date _____,20 _____

Employer (Please Print)

1. Employee's Name
Social Security Number
Group Account Number
Insurance Class

2. Employee's date of full-time hire.
Employee's effective date of insurance with GE Group Life Assurance.
Last day worked.
Was more than half day completed? ☐ Yes ☐ No
Reason for stopping work
Returned to work on.

3. Percentage of Employee Contribution toward disability premium (See Internal Revenue Code 105(a))
We will assume premiums are 100% employer paid if the premium percentage is not indicated _____ %
Employee's contributions were made on: ☐ Pre Tax Basis ☐ Post Tax Basis

4. Occupation at time of disability. (attach functional job description)
Work schedule at time of disability.
Days per week _____ Hours per day _____
5. Basic monthly earnings.
$_____
Date of Last Salary Change ____ / ____
☐ Hourly ☐ Salaried ☐ Salary & Bonus
☐ Salaried & Commission
☐ Commissions Only
☐ Other, explain _____

6. Will (or has) employee file(d) for unemployment compensation or for disability benefits provided by any employer-employee, labor management, or union welfare plan?
☐ Yes ☐ No If yes, please specify:

7. This employee is eligible for salary continuation.
Amount _____ Duration _____
Is this employee eligible for Workers' Compensation? ☐ Yes ☐ No
Has claim been filed? _____ ☐ Yes ☐ No
Carrier
If yes, date began:_____ Weekly Amount _____
Is this employee or will this employee be eligible for a disability or retirement pension?
If yes, effective date _____

Employer _____ Address _____
Signed _____ Title _____ Date _____
Division of _____ Tel. No. (____)_____ Employer (taxpayer) ID Number (EIN) _____

ATTENDING PHYSICIAN'S STATEMENT

Name of patient _____ Date of birth _____

Employer name _____

1. HISTORY
   - (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ 20 _____
   - (b) Date patient ceased work because of disability. Mo. _____ Day _____ 20 _____
   - (c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe.
   - (d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
   - (e) Names and addresses of other treating physicians.
   - (f) Has patient been hospital confined? ☐ Yes ☐ No If yes, give name/address of hospital _____
     Confined from _____ through _____

2. DIAGNOSIS
   - (a) Diagnosis (including any complications). ICD-9 Code _____
   - (b) Objective findings (including current x-rays, EKG, laboratory data and any clinical findings).
   - (c) Subjective symptoms.
   - (d) Diagnosis of pregnancy: Date last L.M.P. _____ Date EDC _____ Date delivery _____

3. DATES OF TREATMENT Remarks
   - (a) Date of first visit. Mo. _____ Day _____ 20 _____
   - (b) Date of last visit. Mo. _____ Day _____ 20 _____
   - (c) Frequency. ☐ Weekly ☐ Monthly ☐ Other (specify) _____

4. NATURE OF TREATMENT (Including Surgery, Rehabilitation and medications prescribed, if any).

5. PROGRESS
   - (a) Has patient reached Maximum Medical Improvement? ☐ Yes ☐ No
   - (b) If no, when do you expect a fundamental change? Mo ____ Day ____ Year ____
   - (c) When will patient recover sufficiently to return to work? Mo ____ Day ____ Year ____

6. VOCATIONAL REHABILITATION
   - (a) Would vocational counseling and/or vocational rehabilitation be recommended? ☐ Yes ☐ No, Why not?
     _____
     _____
   - (b) Would job modification enable patient to work with impairment? ☐ Yes ☐ No If yes, how?
     _____
     _____

7. CARDIAC (If Applicable)
   - (a) Functional capacity (American Heart Ass'n.) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
   - (b) Blood Pressure (last visit) _____ systolic/diastolic

8. FUNCTIONAL LIMITATIONS - ABILITIES
   Indicate frequency per day the listed activity can be performed.
   (n - never, o - occasional, f - frequent, c - constant)

LIFTING	**CARRYING**
_____ 1-5 lbs.	_____ 1-5 lbs.
_____ 6-10 lbs.	_____ 6-10 lbs.
_____ 11-25 lbs.	_____ 11-25 lbs.
_____ 26-50 lbs.	_____ 26-50 lbs
_____ 51-100 lbs.	_____ 51-100 lbs.
_____ over 100 lbs.	_____ over 100 lbs.

Indicate longest single time duration each activity can be performed.

_____ Sitting	_____Kneeling	_____ R Finger Dexterity
_____ Total time on feet		_____ L
_____ Standing	_____ Inside	_____ R Below Shoulders
_____ Walking		_____ L
_____ Bending	_____ Outside	_____ R Above Shoulders
_____ Squatting	_____ Working with Others	_____ L
_____ Stooping	_____ Other (explain) _____	

Reaching

Doctor: Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why?

9. PSYCHIATRIC IMPAIRMENT (if applicable)
   - (a) Please define "stress" as it applies to this claimant.
   - (b) What stress and problems in interpersonal relations has claimant had on job?
     - ☐ 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 stress situations and engage in most interpersonal relations (slight limitations).
     - ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
     - ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
     - ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

10. **Doctor: Please include copies of office notes for the period of treatment, test results, available discharge summaries and any consulting physician reports.**

Name (Attending Physician) Print	Degree	Telephone

Street Address	City or Town	State or Province	ZIP Code

Signature	Date	Taxpayer ID Number (EIN)

The patient is responsible for the completion of this form without expense to the company.