



Phone Number: 1 (800) 778-2281
Fax: 1 (972) 996-9361

Return to Fort Dearborn Life at:
Attention Claims Department
P.O. Box 655403
Dallas, Texas 75265-5403

GROUP NUMBER _____

PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED

- | | |
|--|--|
| <input type="checkbox"/> SHORT-TERM DISABILITY | <input type="checkbox"/> ACCIDENTAL DISMEMBERMENT |
| <input type="checkbox"/> VOLUNTARY STD | <input type="checkbox"/> SPECIFIC DISEASE BENEFIT |
| <input type="checkbox"/> WAIVER OF PREMIUM | <input type="checkbox"/> ACCELERATED DEATH BENEFIT |
| | <input type="checkbox"/> CRITICAL ILLNESS |

CLAIMANT'S STATEMENT (Please Print)

Claimant's Name		Social Security #	Height	Weight	Birth Date
Address					Phone Number
Number	Street	City	State	Zip	A/C ()
Name of employer		Occupation	Maiden Name	Alias Name	

Are you filing a claim for this disability under the Workers' Compensation Act? Yes No
Are you filing a claim for this disability under the Social Security Act? Yes No

Describe other income you are receiving:

YES	NO	TYPE *	AMOUNT	DATE BENEFITS BEGAN	DATE BENEFITS TERMINATED	NAME OF INSURANCE CARRIER
<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 benefits	\$ _____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	_____

**Please send a copy of your award letter, if applicable.*

- Date of accident or beginning of sickness: _____ Date last worked: _____
- Nature of injury or illness: _____
- If injury, describe how, when and where accident occurred: _____
- Have you ever had same or similar illness? Yes No If yes, give dates: From _____ To _____
- Name of hospital(s): _____ Dates confined: From _____ To _____
Address of hospital(s): _____
- Name and address of Doctor(s): _____
Dates of treatment: _____
- Between what dates were you unable to perform any duties? From _____ To _____ From _____ To _____

AGREEMENTS AND AUTHORIZATION: I authorize my employer to disclose all information necessary to process my claim to Fort Dearborn Life Insurance Company (FDL).

I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's claim department or its authorized representative(s) information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize FDL to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

This authorization shall expire on the date that I receive notice of FDL's final decision on my claim. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records.;
- A photocopy of this authorization shall be as valid as the original;

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from FDL.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny my claim.

ANY PERSON WHO KNOWINGLY PRESENTS A 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.

Signature of Employee _____ Date _____



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Employers Statement (***italicized items should only be completed if the claim is for Waiver of Premium*)

Employee's Name		Social Security #		Date of Hire	Effective date of Employee's insurance	
Employer's Name				Employer's Group Number		
Employer's Address						
City				State		Zip
Last Day Worked	<input type="checkbox"/> FT <input type="checkbox"/> PT	Date returned	<input type="checkbox"/> FT <input type="checkbox"/> PT	Base salary \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Class _____ Hours worked per week _____
Worker's Comp Claim filed for this Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		SELF ADMINISTERED ONLY: Amount of weekly disability benefit: \$ _____		Claimant received: Salary continuation through _____ Vacation through _____ Sick Pay through _____		
Employee's Occupation _____						
Premium contribution % by Employer _____ Employee _____ Employee premiums for this coverage pre-taxed? <input type="checkbox"/> Yes <input type="checkbox"/> No						
**Amount of Life Insurance in force:			**Through what date were premiums paid:		**Normal retirement age:	
Signature		Title		Date	Telephone () _____	

ATTENDING PHYSICIAN'S STATEMENT (**Must be completed in full at the patient's expense**)

Patient's Name _____		<input type="checkbox"/> Male	Date of Birth _____	Age _____
Street Address _____		<input type="checkbox"/> Female	City _____ State _____ Zip _____	

- Nature and origin of sickness injury Diagnosis (describe complications, if any): _____
- Date symptoms first appeared or date of accident: _____ Date patient first consulted you for this condition: _____
- Is this condition work related? Yes No _____
- Describe any other disease or complications effecting present condition: _____
- Date and surgical procedure(s), if any: _____
- If maternity give estimated or actual date of delivery: _____ Vaginal C-section
- Please give dates of treatment other than surgical: _____
- Please give hospital name & address with dates of confinement: From _____ To _____ Inpatient Outpatient
Hospital Name _____ Address _____
- Has patient ever had same or similar condition? Yes No (If yes, state when and describe) _____
- Is patient still under your care? Yes No (If discharged give date and degree of recovery) _____
- Is the patient under the care of another physician? Yes No (If yes, provide name, address and phone # of physician) _____
- Patient was or will be continuously disabled (unable to work)
In his/her own occupation From _____ Through _____ In any other occupation From _____ Through _____
Patient can return to work Full time Part time on _____ Restrictions (specify) _____
- Patient was or will be partially disabled? From _____ Through _____
- In your opinion, is patient a candidate for rehabilitation? Yes To return to own occupation For another occupation No
- If patient is diagnosed as terminal, is life expectancy: 6 months or less 12 months or less Other _____

Remarks: _____

Physician's Name _____ Office # () _____ Fax # () _____
 Physician's Signature _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Specialty: FP IM PM&R Neuro Ortho OBG Psych Other _____