Claim Form for Disability Income Insurance Policy

Disability Income Advantage (Form 80315 8/05)

Employee's Statement of Claim (To be Completed by Employee)

Your Name ______________________ Policy Number ______________________

Street Address ______________________

City ______________________ State ______________________ ZIP Code ______________________

Telephone Number (Area Code First) ______________________ Sex ☐ Male ☐ Female Date of Birth ______________________

Employer's Name ______________________

Occupation (List the duties of your occupation at the time of disability) ______________________

Date of first symptoms of illness or date of accident ______________________ Date that you were unable to work due to the disability ______________________

Date returned to work on a part-time basis ______________________ Date returned to work on a full-time basis ______________________

Is your accident or illness related to your occupation? ☐ Yes ☐ No

If "Yes," explain ______________________

Have you or do you intend to file a Workers' Compensation or Occupational Disease law claim? ☐ Yes ☐ No

Describe the onset and nature of your illness or describe how and where accident occurred ______________________

____

____

Date you were first treated for your illness or injury ______________________

Treated by Hospital Name ______________________ Address ______________________

Doctor Name ______________________ Address ______________________

Have you ever had the same or a similar condition in the past? ☐ Yes ☐ No If "Yes," complete the following.

Treated by Hospital Name ______________________ Address ______________________

Doctor Name ______________________ Address ______________________

Describe other income you are currently receiving – ONLY FILL OUT THIS SECTION IF YOU HAVE 24-HOUR COVERAGE

Yes	No	Type	Amount	Date Began	Date Terminated
☐	☐	Social Security (Disability or Retirement)	$		
☐	☐	State Disability	$		
☐	☐	Retirement (normal, early or disability)	$		
☐	☐	Workers' Comp./Occupational Disease	$		
☐	☐	Group Disability	$		
☐	☐	Individual Disability (through employer)	$		
☐	☐	Other	$		

Have you or do you plan to apply for benefit(s) described above? ☐ Yes ☐ No

Type ______________________ Date Application Filed ______________________

Type ______________________ Date Application Filed ______________________

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.

The above Statements are true to the best of my knowledge and belief.

Signature of Employee ______________________ Date ______________________

Kanawha Insurance Company is a wholly-owned subsidiary of KMG America.

210 South White Street, Lancaster, SC 29720 **Mail: Post Office Box 2000, Lancaster, SC 29721-2000**

Claim Form for Disability Income Insurance Policy

Disability Income Advantage (Form 80315 8/05)

Employer's Statement of Claim (To be Completed by Employer)

Employee's Name ______

Policy Number (if known) ______ Date of Birth ______

Address ______

City ______ State ______ ZIP Code ______

Insurance Class ______ Employee Date of Hire ______

Effective Date of Coverage ______ Date Employee last worked ______

Occupation at time last worked ______

Work schedule at time last worked: Number of days per week ______ Number of hours per day ______

Reason for stopping work: ☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Retired ☐ Dismissed ☐ Resigned ☐ Vacation ☐ Other

Has employee returned to work? ☐ Yes ☐ Part Time Date ______ ☐ Full Time Date ______

☐ No

How is employee paid? ☐ Straight Salary ☐ Hourly ☐ Salary and Commissions ☐ Salary & Bonus ☐ Commissions Only

Employee's Basic **Monthly** Earnings $ ______ (if salary is based on less than 12 months, number of months ______)

Employees % of premium contribution: Employee pays: ______% Employer pays: ______%

ONLY FILL OUT THIS SECTION IF YOU HAVE 24-HOUR COVERAGE

Has insured received other disability payments since time last worked? (Include any individual disability insurance if the premiums are paid by or through the employer.)

Salary Continuance ☐ Yes ☐ No Weekly Amount ______ Date Benefits Cease ______

Short or Long Term Disability ☐ Yes ☐ No Weekly Amount ______ Date Benefits Cease ______

Individual Disability Benefits* ☐ Yes ☐ No Weekly Amount ______ Date Benefits Cease ______

Other ☐ Yes ☐ No Weekly Amount ______ Date Benefits Cease ______

**Only include Individual Disability Insurance if premiums are paid by or through the employer.*

Did claim result from job activity? ☐ Yes ☐ No

Has a Workers' Compensation or Occupational Disease law claim been filed? ☐ Yes ☐ No

Workers' Compensation or Occupational Disease law weekly amount $ ______ (Please include first report of accident)

Employer's name ______ Telephone Number ______

Address ______

Printed name of person completing form ______

Signature of authorized representative ______

Title ______ Date ______

Claim Form for Disability Income Insurance Policy

Disability Income Advantage (Form 80315 8/05)

Attending Physician's Statement for Disability Claim

Patient's Name ______________________ Date of Birth ______________________

When did symptoms first appear or accident happen? ______________________

Date patient ceased work due to disability ______________________

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," please describe ______________________

____

Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No ☐ Unknown

Names and addresses of other treating physicians ______________________

____

Diagnosis (including complications) ______________________

If pregnancy, estimated date of delivery ______________________ Subjective symptoms ______________________

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings) ______________________

____

Date of first visit ______________________ Date of last visit ______________________

Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) ______________________

Has patient ☐ Recovered ☐ Improved ☐ Remained Unchanged ☐ Regressed

Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Has patient been hospital confined? ☐ Yes ☐ No If "Yes", please give name of hospital and dates, if known ______________________

____

Cardiac Functional Capacity Limitations (American Heart Association)

☐ Class 1 (none) ☐ Class 2 (Slight) ☐ Class 3 (Marked) ☐ Class 4 (Complete)

Blood Pressure (last visit) ______________________

Physical Impairments (As defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work. No restriction. (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 capacity; capable of clerical/administrative sedentary activity. (60% – 70%)

☐ Class 5 – Severe limitation of functional capacity; capable of minimum sedentary activity (75% – 100%)

Remarks ______________________

Disability Income Advantage (Form 80315 8/05)

Mental Impairments (if applicable)

How does stress affect interpersonal relationships on the job? (Please define "stress" as it applies to this patient.)

- ☐ 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 interpersonal relations. (slight limitations).
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in 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).

Remarks: ______________________________

Is patient now totally disabled? Patient's job ☐ Yes ☐ No Any other work ☐ Yes ☐ No

Date patient became disabled ______________________________

When do you expect a fundamental or marked change? ☐ 1 Month ☐ 2-3 Months ☐ 4-6 Months ☐ Never

Applies to ☐ Patient's job ☐ Other work

When can employment resume in regular occupation? Date ____________ ☐ Full-Time ☐ Part-Time ___% of normal day

When can employment resume in another occupation? Date ____________ ☐ Full-Time ☐ Part-Time ___% of normal day

Remarks – (limitations, therapy, etc.)______________________________

____

____

Printed Name of Attending Physician ______________________________

Degree ____________________ Telephone ____________________

Street Address ______________________________

City or Town ____________ State or Province ____________ ZIP Code ____________

Signature of Attending Physician ____________________ Date____________

As the employee, it is your responsibility to make sure your employer and physician complete their section of this form. For your convenience, you may email this form directly to KMG America or please feel free to contact our Customer Service Center toll free, if you have any questions.

Claims Email: disabilityclaims@kmgamerica.com
Customer Service: (877) 378-1505

210 South White Street, Lancaster, SC 29720 **Mail: Post Office Box 2000, Lancaster, SC 29721-2000**