American Airlines

DISABILITY CLAIM EMPLOYEE STATEMENT

MetLife

Metropolitan Life Insurance Company

PLEASE PRINT OR TYPE

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax number: 1-800-230-9531

Note to Employee: Complete all pages of this form and submit to MetLife at the address shown. Failure to do so may result in a delay in your benefit decision.

Section 1: Personal Information

Name *(Last, First, MI)*	Employer	Social Security #

Address	City	State	Zip Code	Date of Birth *(MM/DD/YY)*	Gender
				mm/dd/yy	☐ M ☐ F

Home Phone #	Work Phone #	Job Title	How long at this position?	Marital Status	W4 Filing Status / Number of Exemptions
				☐ Married ☐ Single ☐ Other	

Dependent Information:

	Name	Date of Birth	Social Security #
Spouse		mm/dd/yy	
Child*(ren)*		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	

Section 2: Claim Information

Is your disability due to ☐ Injury / Accident? ☐ Illness? ☐ Pregnancy? **If due to injury / accident, give date, time and details. *(When, Where, How)***

Have you had previous absences from work due to this disability or another disability? ☐ Yes ☐ No If yes, provide date and medical conditions.
Attach a separate sheet of paper to answer this question if needed.

mm/dd/yy

I (☐ *have* ☐ *have not)* recovered from my Disability. Return to Work: mm/dd/yy Actual or Estimated *(circle one)* Date Recovered: mm/dd/yy

Is this condition work-related? ☐ Yes ☐ No If condition is due to pregnancy, what is your estimated delivery date? mm/dd/yy

Do you have sick time available? ☐ Yes ☐ No If "Yes", provide the number of available hours:

Date of first treatment for this condition	Date Disability Began	Height	Weight
mm/dd/yy	mm/dd/yy		

Name, address, phone number of your primary attending physician.

Name all physicians / providers who have treated you since the beginning of the disability. *(Attach an additional sheet if more space is needed.)*

Name of Physician / Provider	Phone Number	Dates of Treatment	Reason For Visit
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	

Name and address of hospital

Circle Highest Education Level Completed *(number of years)*.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Please describe what prevents you from performing the duties of your job.

Other positions / jobs held prior to current one

Have you applied for or are you receiving income from any other sources? ☐ Yes ☐ No
If yes, provide the following information

	Applied for	Receiving	$ Amount	Frequency	From / To Dates
Salary Continuance / Sick Pay	☐	☐			mm/dd/yy mm/dd/yy
Short Term Disability	☐	☐			mm/dd/yy mm/dd/yy
Worker's Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Social Security	☐	☐			mm/dd/yy mm/dd/yy
Dependent Social Security	☐	☐			mm/dd/yy mm/dd/yy
No Fault *(Income Replacement)*	☐	☐			mm/dd/yy mm/dd/yy
Retirement / Pension	☐	☐			mm/dd/yy mm/dd/yy
Permanent Total Disability *(for Life Insurance)*	☐	☐			mm/dd/yy mm/dd/yy
Unemployment Insurance	☐	☐			mm/dd/yy mm/dd/yy
Work Earnings from Any / All Sources	☐	☐			mm/dd/yy mm/dd/yy
Other *(Please Identify)*	☐	☐			mm/dd/yy mm/dd/yy

Name *(Last, First, Middle Initial)* | Social Security # | Group # | Claim #

Agreement To Reimburse Overpayment Of State Disability or Optional Short Term Disability Benefits

I agree to reimburse Metropolitan Life Insurance Company *(MetLife)* and/or my State Disability or OSTD plan for any over payments of disability benefits I receive under my State Disability or OSTD plan. An overpayment will arise to the extent I receive benefits from my employer's plan that are later determined to be payable to me under *(1)* a Worker's Compensation Law; *(2)* an Occupational Disease law; and/or *(3)* another similar law. An overpayment will also occur if I fail to notify MetLife when I return to work and continue to receive State Disability or OSTD benefits. When an overpayment arises, I agree to reimburse MetLife and/or my employer's State Disability or OSTD plan for the overpayment from the proceeds I receive under such a law. If requested to do so, I will also permit my employer to deduct the overpayment from my salary or any other benefits that may become due me, *(and if appropriate, to reimburse MetLife)* to the extent permissible by law.

Agreement To Reimburse Overpayment Of Long Term Disability Benefits

I acknowledge that, if my disability claim is or has been approved, under my Long Term Disability coverage, Metropolitan Life Insurance Company *(MetLife)* is authorized, as stated in my employer's plan, to reduce the benefits other wise payable to me by certain amounts paid or payable to me under the disability provision of the Social Security Act *(including any payments for my eligible dependents)*, under a Workers' Compensation or any occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

I understand that if my disability claim is approved, MetLife may make monthly disability payments to me, which because of amounts paid or payable under the laws described above may be in excess of the benefits actually due to me. MetLife will make these payments, only if I agree as follows:

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefits payment or a compromise settlement.

2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my employer's plan after I have received my first monthly LTD benefit check from MetLife. As proof of this, I agree to send MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application. If any retroactive Social Security Award is made after I have received LTD payments from MetLife, I agree to repay the full amount of any over payment created by such Social Security Award.

3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my initial application for benefits.

4. As specified in my employer's plan, when I, my spouse or my dependents receive any disability payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award or notification to MetLife.

5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, I agree to repay to MetLife any and all such amounts which MetLife has advanced to me.

6. If for any reason MetLife is not repaid, then I agree that MetLife may reduce my monthly LTD benefit below the minimum monthly benefit amount as stated in my employer's plan, until the over payment is reimbursed in full.

7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

I understand that when MetLife issues a payment, it is relying on my statement and agreements herein. My acceptance of such payment, along with my signature below, is my acceptance of terms of this Agreement.

Claimant's Signature | **Date** (mm/dd/yy)

You have a right to receive a copy of this authorization on request.

MetLife

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department Health and Human Services pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Instructions for completing the form:

1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document*(s)* authorizing you to act on the Employee/ Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan

_____ _____

Name of Employee *(Please Print)* **Social Security Number**

Claim Number_____

Authorization to Disclose Information About Me

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan *(which may include assisting me in returning to work)*, and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company *("MetLife")*, my employer in its capacity as administrator of its disability benefit plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and disability claim.
2. **I permit** MetLife to disclose to my employer in its capacity as administrator of its benefit plans, or to any of the plan administration.

This Authorization to Disclose Information About Me specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

I understand that I may revoke this authorization at any time by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40512, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy up on request.

_____ mm/dd/yy

Signature of Employee **Date**

Disability Claim Employee Statement *(Continued)*

Fraud Warning:

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia – 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.

Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona – 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 loss is subject to criminal and civil penalties.

California – For your protection, California law requires the following to appear on this form: 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.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading 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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma – WARNING: Any person who knowingly and with the 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.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky – Any person who knowingly and with the intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia and Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland – 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 Hampshire – A person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

Oregon and Vermont – Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Disability Claim Employee Statement *(Continued)*

Fraud Warning *(continued)*:

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars *($5,000)*, not to exceed ten thousand dollars *($10,000)*; or imprisoned for a fixed term of three *(3)* years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five *(5)* years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two *(2)* years.

Texas – 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.

Pennsylvania and all other states – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

New York – 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.

Name of Employee *(Please Print)*:_____ Social Security Number:_____-____-_____

Signature of Employee:_____ Date:_____

American Airlines

MetLife

DISABILITY CLAIM
EMPLOYER STATEMENT

PLEASE PRINT OR TYPE

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax number: 1-800-230-9531

Note to Supervisor: Complete all sections below and submit to MetLife at the address shown. Failure to do so may result in a delay in employee's benefit decision.

New York – 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.

TO BE COMPLETED BY LOA/FIELD SUPERVISOR

Employee Name *(Last, First, MI)*	Social Security #	Employee ID #

Subsidiary or Work Group Employee *(check one box)* ☐ Flight Attendant ☐ Transport Workers Union ☐ Pilot ☐ Management ☐ Support Staff

Company: ☐ American Airlines ☐ American Eagle

Occupation / Job Title - Please attach written job description, including the essential job functions.

Work Location Address *(Including state where employment is based)*

Supervisor Name _____ Supervisor Phone # _____

Address _____

Supervisor E-Mail Address _____

Employee last day physically at work	**Last Date Paid**	**Average Hours Worked Per Week.** ***(prior to disability)***
mm/dd/yy	mm/dd/yy	

Does the Employee have sick time available? ☐ **Yes** ☐ **No** **If "Yes", provide number of available hours:** _____

Has the employee filed a claim for Worker's Compensations benefits? ☐ Yes ☐ No

Has an accident report been filed? ☐ Yes ☐ No

If yes, provide name and address of Worker's Compensation Carrier.

Name _____ Phone # _____

Address _____ FAX # _____

Contact Person's Name _____ Worker's Comp. Claim # _____

Date Returned To Work mm/dd/yy ☐ Actual ☐ Estimated

Are you able to accommodate Transitional Duty to return to work? ☐ Yes ☐ No If yes, describe below.

Has return to work been discussed with employee? ☐ Yes ☐ No

If you have questions or other information pertinent to this claim, please contact MetLife at 1-888-533-6287

Disability Claim Statement *(Continued)*

Name of Employee: _____ **Social Security Number:** _____

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Disability Claim Statement *(Continued)*

Name of Employee: _____ **Social Security Number:** _____

Fraud Warning *(continued)*:

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Employer's Authorized Representative

Supervisor's Authorization Signature	Title	Phone #

Signature	Date
	mm/dd/yy

American Airlines

DISABILITY CLAIM
ATTENDING PHYSICIAN STATEMENT

MetLife

Note to Employee: Complete the first section and forward this statement to your attending physician for completion, then submit it to MetLife at:

If you have more than one physician, please use additional forms.

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax number: 1-800-230-9531

The following section must be completed and signed by the employee/patient.
Any fee for the completion of this form is the patient's responsibility.

Occupation *(job title)*

Name | Social Security # | Employer

I hereby authorize my physician to release any information acquired in the course of my examination or treatment.

Signature of Employee_____ Date mm/dd/yy

Date of Birth mm/dd/yy

The following section must be completed and signed by the attending physician.
The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form. Failure to do so may result in a delay of your patient's benefit decision. A MetLife claim representative may telephone your office if additional information is needed.

History

Symptoms result from: ☐ Injury ☐ Illness ☐ Pregnancy *(If pregnancy-related, please complete pregnancy section below)*

Is condition work-related? ☐ Yes ☐ No Initial date of treatment mm/dd/yy

Date disability commences (DDC): mm/dd/yy Estimated dates of confinement: mm/dd/yy

Did you advise the patient to cease the above-noted occupation? ☐ Yes ☐ No If Yes, provide date mm/dd/yy

In your opinion, why is the patient unable to perform job duties?

If patient was referred to you, by whom? Please provide name and phone number.

Names and Phone Numbers of the other providers the patient was referred to:

Name Phone # Name Phone #

Has patient been hospitalized? ☐ Yes ☐ No If Yes, provide dates from mm/dd/yy to mm/dd/yy

Name and address of facility

Pregnancy *(Please also complete the Diagnosis and Treatment section below)*

Most recent date of treatment mm/dd/yy

Delivery date mm/dd/yy ☐ Expected ☐ Actual Delivery type: ☐ Vaginal ☐ Cesarean

Is recommendation not to work due to preventive reasons? ☐ Yes ☐ No

Did patient suffer any totally disabling complication of pregnancy? ☐ Yes ☐ No

If yes, please explain

Diagnosis and Treatment

Primary Diagnosis Code_____ Diagnosis_____

Secondary Diagnosis Code_____ Diagnosis_____

Height_____ Weight_____

Subjective Symptoms

OBJECTIVE FINDINGS *(INCLUDE COPIES/RESULTS OF ANY X-RAYS, LAB TESTS, EKG'S, MRI'S, SCANS AND OFFICE NOTES)*

Current and Recommended Treatment Plans_

If surgery performed / anticipated, provide the following:

CPT-4_____ Procedure_____ Date mm/dd/yy

Medications prescribed *(names, dosages)*

Psychological Functions

Check applicable box below

- ☐ 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 some 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)*

Remarks:

What stress factors or problems with interpersonal skills have affected patient's ability to perform the duties of his or her job?

Is patient competent to endorse checks and direct use of the proceeds? ☐ Yes ☐ No

Physical Capabilities *(Check all that apply which are supported by clinical findings)*

(A) The patient can perform the following in an 8-hour workday *(specify percentage)*:

Sitting	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Standing	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Walking	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Climbing	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Bending / Stooping / Twisting	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Reaching above Shoulder Level	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Handling - Right Hand	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Left Hand	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Fingering - Right Hand	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Left Hand	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%

(B) Patient's ability to lift / carry: *(check)*

Up to 10 lbs.	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
11 to 20 lbs.	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
21 to 50 lbs.	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
51 to 100 lbs.	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%
Over 100 lbs.	☐ 0%	☐ 1-5%	☐ 6-33%	☐ 34-66%	☐ 67-100%

(C) Push / pull force:_____lbs. ☐ 0% ☐ 1-5% ☐ 6-33% ☐ 34-66% ☐ 67-100%

(D) Patient's dominant hand: ☐ Right ☐ Left

(E) Other work or activity restrictions. Please be specific.

Cardiac

Functional Capacity *(American Heart Association)* Complete only if applicable.

☐ Class 1 *(No Limitation)* ☐ Class 2 *(Slight Limitation)* ☐ Class 3 *(Marked Limitation)* ☐ Class 4 *(Complete Limitation)*

Blood pressure *(latest reading)*_____ as of *(date)* mm/dd/yy

Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No Stress test performed? ☐ Yes ☐ No Please attach report.

Prognosis for Return to Work

Have you advised patient to return to work?

☐ Yes If Yes, date of return mm/dd/yy ☐ To regular occupation ☐ Full Time ☐ Part Time

☐ No If not, please explain. ☐ To any other occupation ☐ Full Time ☐ Part Time

Is patient able to return to modified work? ☐ Yes ☐ No

If so, specify any applicable work / activity restrictions.

Rehab

Do you suggest that the patient become involved in any of the following? Please check as many as apply.

If so, was this discussed with the patient? ☐ Yes ☐ No Dates mm/dd/yy

☐ Physical Therapy ☐ Pain Management Program ☐ Vocational Rehabilitation

☐ Occupational Therapy ☐ Work Hardening Program ☐ Psychological Counseling

☐ Cardiac Rehabilitation ☐ Job Modification ☐ Other_____

American Airlines Employer Health & Wellness Services with ActiveHealth _____

*Online and telephone health coaching for weight, diabetes, blood pressure, chronic pain, back care, quitting smoking, dealing with stress

*Call Healthmatters at 1-888-227-6598 to schedule a call with a Health Advocate team member.

Disability Claim Attending Physician Statement *(Continued)*

Name of Employee:_____ Social Security Number:_____

Fraud Warning:

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

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Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona – 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 loss is subject to criminal and civil penalties.

California – For your protection, California law requires the following to appear on this form: 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.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading 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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma – WARNING: Any person who knowingly and with the 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.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky – Any person who knowingly and with the intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia and Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland – 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 Hampshire – A person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

Oregon and Vermont – Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Disability Claim Attending Physician Statement *(Continued)*

Name of Employee:_____ Social Security Number:_____

Fraud Warning *(continued)*:

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars *($5,000)*, not to exceed ten thousand dollars *($10,000)*; or imprisoned for a fixed term of three *(3)* years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five *(5)* years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two *(2)* years.

Texas – 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.

Pennsylvania and all other states – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

New York – 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.

Physician

Name_____ Degree/Specialty_____

Street Address_____ City_____ State_____ Zip Code_____

Telephone #_____ Fax #_____ Tax ID #_____

Contact person if additional information is necessary

Signature_____ Date mm/dd/yy_____