Beazley Insurance Company, Inc.
Administrative Services provided by:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: 800-508-9238
aciclaims@acitpa.com
Fax: 610-293-9299

Claim Form
Group Limited Indemnity
Total Disability Rider
(For Short Duration Disability or Short Term Disability Claims)

INSTRUCTIONS – PLEASE READ CAREFULLY:

- **Section 1A through 1D: To be completed and signed by insured.**
- **Section 2A & 2B: To be completed and signed by attending physician.**
- **Section 3: To be completed and signed by employer's authorized representative.**
- **Please submit completed claim form to the address listed.**

SECTION 1A: CLAIMANT INFORMATION

Last Name	First Name	M.I.	Social Security Number	Date of Birth

Street Address	Apt. No.	City	State	Zip Code

Home Phone: ( )	Work Phone: ( )	E-Mail Address:

Group Name:	Group Number:

Your Occupation:	Duties:

Eligible to Receive Any Other Income: ☐ Yes ☐ No	Type of Benefits: ☐ Social Security ☐ Workers Compensation ☐ State Disability ☐ Pension ☐ No-Fault ☐ Other: _____

Benefits Provider:	Contact (if applicable):	Phone: ( )	Monthly Benefit Amount: $

NOTE TO CLAIMANT: If your claim is approved for benefits and you would like federal income taxes withheld, please provide a completed WS-4 form and submit it with this claim form.

SECTION 1B: TOTAL DISABILITY

If applying for Total Disability, provide the dates you were unable to perform any job duties: From: ____/____/____ To: ____/____/____

SECTION 1C: SIGNATURE *(This form must be signed.)*

AUTHORIZATION AND ACKNOWLEDGMENT

I certify that the above information is true and correct to the best of my knowledge and belief.

X _____ _____

Signature of Claimant | Date Signed

SECTION 1D: AUTHORIZATION TO RELEASE INFORMATION *(This section must be signed.)*

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support or, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose, death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol to determine eligibility for benefit payments under the Policy Number identified above. I authorized the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this is valid for the term of coverage of the Policy identified above and that a copy of this authorization

shall be considered as valid the original. I understand that I or my authorized representative may request a copy of this authorization.

X _____ _____

Signature of Claimant | Date Signed

SECTION 2A: ATTENDING PHYSICIAN'S STATEMENT

Diagnosis:	ICDA-9 Code(s):	Height:	Weight:
Patient's Disability Due To: ☐ Employment ☐ Accident ☐ Pregnancy ☐ Other _____			
If disability is due to pregnancy, provide date of delivery: Actual: ____/_____/_____ Estimated: ____/_____/_____			
Indicate LMP: ____/_____/_____	Type of Delivery: ☐ Vaginal ☐ C-Section ☐ Multiple Births		
Date of First Symptoms:	Date of First Visit for This Condition:	Dates of Treatment for This Condition:	
Date(s) Patient Hospitalized:	Surgical Procedure Date(s):	Type of Surgical Procedure:	
Date Patient was Totally Disabled (Unable to Work): From: ____/_____/_____ Through: ____/_____/_____		Anticipated Return to Work Date:	
If relevant, provide how long the patient will be partially disabled (unable to perform one or more of his job duties or only able to work 80% of his regularly schedule work hours: ___ ☐Day(s) ☐Week(s) ☐Month(s) ☐ Year(s)	Please provide additional details:		

Patient's Physical Limitations/Restrictions:

Lifting:	☐ Less Than 15 lbs	☐ 15 – 44 lbs	☐ Over 45 lbs
Stooping or Bending:	☐ None	☐ Seldom	☐ Frequent
Crawling, Climbing or Kneeling:	☐ None	☐ Seldom	☐ Frequent
Reaching, Pulling or Pushing:	☐ None	☐ Seldom	☐ Frequent
Repetitive _____:	☐ None	☐ Seldom	☐ Frequent
Management Duties:	☐ None	☐ Seldom	☐ Frequent
Sitting:	_____ Hours Each Day		

Patient Still Under Your Care: ☐ Yes ☐ No	Medically Necessary Activity Restrictions: ☐ Yes ☐ No
List Specific Activity Restrictions:	
Date of Patient's Next Appointment:	

SECTION 2B: ATTENDING PHYSICIAN'S SIGNATURE *(This section must be signed)*

Printed Name of Physician:			Tax ID:	
Street Address	Apt. No.	City	State	Zip Code
Phone Number: ( )	Fax Number: ( )	E-Mail Address:		

I hereby certify that the above information is true and correct to the best of my knowledge.

X _____ _____

Signature of Physician | Date Signed

SECTION 3: EMPLOYER STATEMENT *(This section must be completed in full and signed)*

Employer Name:			Group Number:	
Printed Name of Authorized Person:			Title:	
Street Address:	Ste. No.:	City:	State	Zip Code:

If Branch or Affiliate, Name of Parent Company:	Employer Tax ID Number:

Phone Number:	Fax Number:	E-Mail Address:

Employee Name:	Employee Date of Birth:	Employee Social Security Number:

Employee Job Title:	Date of Hire:	Normal Work Schedule: Hours/Week: _____ Hours/Day: _____

Pay Frequency: ☐Hourly ☐Weekly ☐Bi-Weekly ☐Semi-Monthly ☐Monthly ☐Yearly

Effective Date of Beazley Disability Income Policy:	Effective Date of Insurance with Previous Carrier :

Employment Related Disability: ☐ Yes ☐ No	If yes, please provide details:	Worker's Compensation Claim Filed: ☐ Yes ☐ No

Termination Date (if applicable):	Reason for Leaving Work: ☐ Disability ☐ Resigned ☐ Terminated ☐ Layoff ☐ Leave of Absence ☐ Retirement

Job can be modified to allow for return to work: ☐ Yes ☐ No ☐ Maybe, dependent on restrictions	Employee Return to Work Date: ____/_____/_____ Full Time ____/_____/_____ Part Time

Salary for Hourly employees: If earnings fluctuate based on hours worked, please provide the following:
(Please include tips, bonus, overtime and commissions.

Base Salary for hourly employees: $_____monthly $_____weekly

The previous 52 weeks of income prior to the date this disability began: _____ The previous 104 weeks of income prior to the date the disabilty began: _____

Salary for Exempt employees:
Base Salary for exempt employees: $ _____ monthly $_____ weekly

(Exclude tips, bonus, overtime and commissions.)

Weekly Earned Income for exempt employees: If earnings fluctuate based on hours worked, please provide the following:
(Please include tips, bonus, overtime and commissions.)

-The previous 104 weeks of income prior to the date the disabilty began: _____

NOTE TO EMPLOYER:
BEAZLEY WILL WITHHOLD THE EMPLOYEE PORTION OF FICA PAYMENTS ONLY AND PROVIDE ONGOING REPORTS TO YOUR COMPANY.

Employee contributes to the cost of their short term disability premium: ☐ Yes ☐ No	If yes, what % is paid by employee: _____ % ☐ Pre-Tax ☐ Post-Tax

I certify that I have reviewed the above information and the employee named above has been full time active employee for who premiums have been paid. I hereby certify that the above information is true and correct to the best of my knowledge.

X _____ _____

Authorized Employer Signature Date Signed

FRAUD WARNINGS

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 any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

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 a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, 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.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia - 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.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas – It is unlawful to commit a fraudulent insurance act, which means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Kentucky - 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.

Maine, Tennessee, Virginia, 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire - Any 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.

New Mexico – Any person who, with intent to defraud or knowing that he or 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.

Ohio - Any person who, with intent to defraud or knowing that he 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.

Oklahoma - 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 false, incomplete or misleading information is guilty of a felony.

Oregon - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania - 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 subjects such person to criminal and civil penalties.

Vermont - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.