First Continental Life & Accident Insurance Co.

Disability Claim Form

Please follow these instructions when filing a claim:

(A) Complete all questions CLAIMANT'S STATEMENT, Part I. If additional space is needed, attach separate sheet.
(B) Sign and date completed form.
(C) Have EMPLOYER'S STATEMENT, Part II, completed and signed by your employer (Reverse
(D) Have DOCTOR'S STATEMENT, Part III, completed and signed by your doctor (Reverse Side)
(E) Mail form to: Administrative Concepts, Inc., P.O. Box 4000, Collegeville, PA 19426-9000
www.acitpa.com Fax: 610-293-9299 Call: 800-565-6053 email: claims@acitpa.com

IN ORDER TO AVOID DELAY, PLEASE ANSWER ALL QUESTIONS COMPLETELY

PART I CLAIMANT'S STATEMENT

Insured's Name First M.I.	Social Security number	Date of birth	Certificate #

Residence
Residence telephone #
Business telephone #

Were you employed when disability began ❑ Yes ❑ No	If yes, give your occupation, employer's name and address
Date of accident	Describe injuries sustained. If accident, state where or how it occurred.

Date you stopped working because of this condition Date you resumed any work?	Period of total disability From: To:	Period of partial disability From: To:	List job duties you are unable to perform while partially disabled or residually disabled.

Medical treatment in the past five years, including current physicians:
Date Doctor, hospital or clinic name Address

List other sources of disability income benefits claimed, including Worker's Compensation and Social Security, (if none, indicate by writing "none".)
Company/organization Address Policy/claim # Benefit amount

Have you filed for Social Security Disability income?
❑ Yes ❑ No If yes, please enclose a copy of the award or denial letter.

Is the condition related to an auto accident? ❑ Yes ❑ No If yes, please provide us with a copy of the accident report.	If yes, provide name and address of the insurance company. Include policy #.

Are you self-employed? If yes, indicate type of business entity: ❑ Sole proprietorship ❑ Partnership ❑ C Corp ❑ S Corp
❑ Yes ❑ No Does your employer/business contribute to payment of your premiums? ❑ Yes ❑ No

I *authorize* any physician, health care practitioner, pharmacy, hospital, other medical facility, insurance company, employer, benefit plan administrator, Veteran's Administration, Internal Revenue Service, consumer reporting agency, financial institutions, the Social Security Administration, any insurance support organization, release all information regarding the non-medical and medical history, diagnosis and prognosis, treatment, (including drug and alcohol abuse information), disability, employment, earnings or benefits under other insurance coverage to First Continental Life and Accident Insurance Company, EQUIFAX Services or any Consumer Reporting Agency acting on behalf of the Company for the purpose of determining benefits payable in connection with any claim, or any other use as law permits.

I authorize First Continental Life and Accident Insurance Company or its reinsurers to request dates of past and present claims and names of insurers , excluding medical orpersonal information, from the Health Claims Index operated for subscriber insurers by the Medical Information Bureau (MIB), an association of life insurance companies. I understand the dates of my past and present claims may be reported to MIB.

A copy of this authorization will be sent to me upon request. This photocopy of the original shall be valid for two years from the date of the signature, or for the duration of the claim, whichever is longer.

Any person who knowingly presents a false or fraudulent claim for payment of 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.

Please see attached form.

Signature **Date**

(over)

PART II EMPLOYER'S STATEMENT

This section must be completed if the business actually contributes to the premiums for the insured's Policy(s):

- Employers/Business's contribution to the premiums for this policy(s) is _____%
- Employers/Insured has paid the maximum FICA taxes for the current year ❑ Yes ❑ No
- Employers/Business is exempt from Social Security Taxes ❑ Yes ❑ No
- Employer Tax ID # _____

_____ _____
Authorized Representative Signature Date

(Do not complete the balance of this Employer's Statement if the insured is self-employed.)

Employer's name | Business telephone # ( )

Street address | City | State | Zip Code

Claimant's occupation? | Weekly Salary | Usual duties?

Full-time work
Date ceased? | Date resumed?

Part-time work
Date ceased? | Date resumed?

Name and address of compensation carrier *(if applicable)* | Representative's name/phone

Please list any other disability benefits this employee is eligible for through your company.

Date | Employer's Signature | Official position/title | Phone number ( )

PART III ATTENDING PHYSICIAN'S STATEMENT (Please Answer All Questions)

Diagnosis (Standard Medical Nomenclature) ICE8.CM a/o DSM III.R codes and impairments:

Diagnosis and concurrent conditions
(If diagnosis code other than ICDA used, give name):

Date symptoms first appeared or accident happened: | Date patient first consulted you for this condition: | Has the patient ever had same or similar condition before? ❑ Yes ❑ No If yes, when?

Is present condition the sole cause of disability? ❑ Yes ❑ No | If not, what are other contributing factors?

If patient has been hospitalized, give date | Name and address of hospital

Dates of total disability
From: To: | Date of partial disability
From: To: | Is the patient competent to endorse checks and direct the use of the proceeds thereof? ❑ Yes ❑ No

EXTENT OF DISABILITY

	From any occupation	From patient's regular occupation
(a) Is patient now totally disabled?	❑ Yes ❑ No	❑ Yes ❑ No
(b) If no, when was patient able to go to work?	Mo._____Day_____Yr._____	Mo._____Day_____Yr._____
(c) If yes, please estimate when patient will be able to resume working? **Approx. date**	Mo._____Day_____Yr._____	Mo._____Day_____Yr._____
	❑ 1-3 months ❑ 6-12 months ❑ 3-6 months ❑ Never	❑ 1-3 months ❑ 6-12 months ❑ 3-6 months ❑ Never

Name and address of referring physcian | Name and address of any other practitioner treating this patient

Dates of treatment

Date | Attending physician (please print) | Signature | Degree | Telephone

Street address | City or town | State (or province) | Zip code

(over)

Important Notice

- In General, and specifically for residents of Arkansas, Illinois, Louisiana, 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.
- For Residents of Alabama: 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 restitution fines and confinement in prison or any combination thereof.
- For residents of 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.
- For residents of the 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
- For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application for insurance containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- For residents of 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.
- For residents of 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 include imprisonment, fines and denial of insurance benefits.
- For residents of Oregon: Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- For residents of 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.
- For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.
- For residents of 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 factual 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.
- For residents of 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.
- For residents of 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 any false, incomplete or misleading information is guilty of a felony.
- For residents of 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.