Amalgamated Life
Group • Stop Loss • Voluntary

Amalgamated Life Insurance Company Disability
Benefits Claim Department
P.O. Box 7315, Bedminster, NJ, 07921
Toll-Free: 1-866-975-4089 / FAX: 908-655-9826

Voluntary Benefits – Disability Income Claim Form

Attending Physician's Initial Statement of Disability

CLAIMANT INFORMATION – To be Completed by the Claimant/Patient

Policy Number	Social Security #	Gender Male ☐ Female ☐

Claimant/Patient Name (First) (Middle) (Last)	Age	Date of Birth ___ __ ___ mm dd yyyy

Home Address (Street) (City) (State) (Zip)

ATTENDING PHYSICIAN STATEMENT

Is patient continuously totally disabled? Yes ☐ No ☐ If "No," is patient continuously partially disabled? Yes ☐ No ☐

Date patient became totally disabled ___ __ ___ (mm dd yyyy) Did you advise patient to stop working? Yes ☐ No ☐ If Yes, date ___ __ ___ (mm dd yyyy)

**TOTALLY DISABLED OR TOTAL DISABILITY means that You are under the Regular Care and Attendance of a Physician and that for the first 24 months of Total Disability, You are unable to perform the material and Substantial Duties of Your Own Occupation due to Sickness, or Injury; and You are not engaged in any other occupation.*

If applicable, date patient became partially disabled ___ __ ___ (mm dd yyyy) Explain reason for partial disability.

CONDITION AND DIAGNOSIS

Is disability due to sickness? Yes ☐ No ☐ If Yes, date symptoms first appeared ___ __ ___ (mm dd yyyy)

Is disability due to accident or injury? Yes ☐ No ☐ If Yes, date of accident or injury ___ __ ___ (mm dd yyyy)

Primary diagnosis causing disability ICD Code

Secondary diagnosis if impacting disability ICD Code

Description of condition or complications:

Is the condition related to the patient's employment? Yes ☐ No ☐

If Yes, explain how it is work-related:

Is the condition related to an automobile accident? Yes ☐ No ☐ If Yes, date of accident ___ __ ___ (mm dd yyyy)

To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment advice or recommendations for this condition prior to this onset of disability? Yes ☐ No ☐

If Yes, provide information:

Was this patient referred to you? Yes ☐ No ☐ If Yes, provide name, specialty, address, and telephone number of referring physician(s).

Name	Specialty	Address	Phone No.

Patient Name: _____ Policy Number: _____

TREATMENT INFORMATION

Date you first attended patient for this disability ___ mm __ dd ___ yyyy Date you last attended patient ___ mm __ dd ___ yyyy

Other treatment dates for this disability

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other If Other, specify

If patient has been hospitalized for this disability, provide reason for admission and dates.

If surgery was or will be performed, provide type of surgery and date(s).

Advise all medications prescribed

Describe present treatment plan

Prognosis ☐ Terminal ☐ Poor ☐ Good ☐ Excellent

Has patient reached maximum improvement ☐ Yes ☐ No If No, estimate when ___ mm __ dd ___ yyyy

Is patient a candidate for cardiac, physical or vocational rehabilitation? Yes ☐ No ☐

Has rehabilitation been recommended? Yes ☐ No ☐ If Yes, has patient complied? Yes ☐ No ☐

MATERNITY (If Applicable)

Is this disability due to pregnancy ☐ Yes ☐ No

Expected delivery date ___ mm __ dd ___ yyyy If delivered, date ___ mm __ dd ___ yyyy ☐ Normal ☐ C-section

(a) If disability is prior to delivery, what are the complicating factors (be specific)

(b) Were there any post-delivery complications? ☐ Yes ☐ No

If Yes, please explain:

PSYCHIATRIC IMPAIRMENT (If Applicable)

☐ 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 only limited 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

Please define **stress** as it applies to this patient.

CARDIAC (If Applicable)

Functional Capacity (American Heart Association)

☐ 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 ___ yyyy

Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

Patient Name: _____ Policy Number: _____

VISUAL IMPAIRMENT (If Applicable)

Complete this section IF disability is due to Visual Impairment.

What was vision at last observation? *(Snellen Notation)*

with glasses O.D. _____ O.S. _____ Date ___ __ ___ mm dd yyyy

without glasses O.D. _____ O.S. _____ Date ___ __ ___ mm dd yyyy

Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye _____

☐ O.D ☐ O.S.

Vision can be restored in whole or in part by: O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable

O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable

PHYSICAL RESTRICTIONS AND FUNCTIONAL CAPACITY

In a work day, patient can stand:
(Hours at one time) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10
(TOTAL hours during day) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

In a work day, patient can walk:
(Hours at one time) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10
(TOTAL hours during day) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

In a work day, patient can sit:
(Hours at one time) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10
(TOTAL hours during day) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

In a work day, patient can drive:
(Hours at one time) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10
(TOTAL hours during day) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

Patient can lift:	Never	Occasionally (Up to 33%)	Frequently (34%-66%)	Continuously (67%-100%)
< 1 lbs	☐	☐	☐	☐
1 - 10 lbs	☐	☐	☐	☐
11 - 20 lbs	☐	☐	☐	☐
21 - 30 lbs	☐	☐	☐	☐
31 - 40 lbs	☐	☐	☐	☐
41 - 50 lbs	☐	☐	☐	☐
51 - 100 lbs	☐	☐	☐	☐
101 - 501 lbs	☐	☐	☐	☐

Patient can carry:	Never	Occasionally (Up to 33%)	Frequently (34%-66%)	Continuously (67%-100%)
< 10 lbs	☐	☐	☐	☐
11 - 20 lbs	☐	☐	☐	☐
21 - 50 lbs	☐	☐	☐	☐

Patient Name: _____ Policy Number: _____

Patient can:	Never	Occasionally (Up to 33%)	Frequently (34%-66%)	Continuously (67%-100%)
BEND/TWIST AT WAIST	☐	☐	☐	☐
BEND/TWIST AT NECK	☐	☐	☐	☐
SQUAT	☐	☐	☐	☐
CRAWL	☐	☐	☐	☐
CLIMB	☐	☐	☐	☐
BALANCE	☐	☐	☐	☐
REACH (BELOW SHOULDER)	☐	☐	☐	☐
REACH (ABOVE SHOULDER)	☐	☐	☐	☐
COMPUTER KEYBOARDING	☐	☐	☐	☐
MOUSE USAGE	☐	☐	☐	☐

HANDLING

	Simple Grasping	Fine Manipulation	Pushing and Pulling
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dominant Hand:	☐ Right ☐ Left		

ACTIVITY RESTRICTIONS INVOLVING:	Total	Moderate	Mild	No Restriction
Fixed/Moving Machinery	☐	☐	☐	☐
Cold Climate	☐	☐	☐	☐
Hot Climate	☐	☐	☐	☐
Wet/Humid	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Dust/Fumes	☐	☐	☐	☐
Use of Powered Equipment	☐	☐	☐	☐
Vibration	☐	☐	☐	☐

WORK CAPABILITIES

Have you reviewed the patient's job description? ☐ Yes ☐ No

Would job modification enable patient to work with impairment? ☐ Yes ☐ No

Will patient recover sufficiently to perform the essential duties of his/her regular occupation? ☐ Yes ☐ No

Do you know if patient has returned to work? ☐ Yes ☐ No If Yes, date ___ __ ___ (mm dd yyyy)

Has or will patient recover to return to work as indicated below:

Regular occupation, full-time?	☐ Yes	What date	☐ No	Estimate
Regular occupation, part-time?	☐ Yes	What date	☐ No	Estimate
Any other occupation, full-time?	☐ Yes	What date	☐ No	Estimate
Any other occupation, part-time?	☐ Yes	What date	☐ No	Estimate

CONFIRMATION OF DISABILITY

Certify the period that patient is/was continuously Totally Disabled From ___ __ ___ (mm dd yyyy) Through ___ __ ___ (mm dd yyyy)

Certify the period that patient is/was continuously Partially Disabled From ___ __ ___ (mm dd yyyy) Through ___ __ ___ (mm dd yyyy)

Patient Name: _____ Policy Number: _____

FRAUD WARNING

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 in the following states, please see the last page of this form. Alabama, Alaska, Arizona, California, Colorado, Delaware, District of Columbia, Florida, Idaho, Indiana, Kentucky, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Virginia and Washington.

PHYSICIAN INFORMATION AND SIGNATURE

Physician's name (print)_____ Degree/Specialty _____

Street address _____ City _____ State _____ Zip _____

Telephone no. (_____) _____ Fax no. (_____) _____

▶ Signature _____ Date ___ __ ___ _____

mm dd yyyy Do Not Pre-Date Physician's EIN or SSN

(The patient must pay for any costs for completion of this form)

FRAUD WARNINGS FOR CLAIM FORMS

Alabama, Arkansas, Louisiana, Massachusetts, New Mexico, Rhode Island and West Virginia Residents: 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.

Maine, Tennessee, Virginia and Washington Residents: 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.

Delaware , Florida, Idaho and Indiana Residents: 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.

Alaska Residents: 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 the law.

Arizona Residents: 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.

California Residents: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: 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.

District of Columbia Residents: 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.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer 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 Residents: Any person who knowingly and with 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.

Maryland Residents: 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.

Minnesota Residents: 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 Residents: Any person who, with a purpose to injure 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 N.H. Rev. Stat. Ann. §638.20.

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

Ohio Residents: 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 Residents: 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.

Oregon Residents: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement 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.

Texas Residents: 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.