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

Claimant Initial Statement of Disability

CLAIMANT INFORMATION

Policy Number	Social Security #	Gender Male ☐ Female ☐

Claimant Name (First) (Middle) (Last)	Age	Date of Birth mm dd yyyy

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

Have you moved since your Policy Application? Yes ☐ No ☐ If "Yes," is the above address your new address? Yes ☐ No ☐

Home Telephone No.	Cell Telephone No.	Email Address

Employer Name	Employer Address	Employer Telephone No.

CLAIMANT DATES OF DISABILITY AND WORK STATUS

Have you been continuously totally disabled? Yes ☐ No ☐ If "No," have you been continuously partially disabled? Yes ☐ No ☐

I became disabled on mm dd yyyy	My last date of work was mm dd yyyy	I worked on that day Yes ☐ No ☐

Have you since worked for wages or profit? Yes ☐ No ☐ If "Yes," give dates to mm dd yyyy

Have you returned to work? Yes ☐ No ☐ If "Yes," indicate date mm dd yyyy Full Time ☐ Part Time ☐

If you have not returned to work, when do you expect to return? mm dd yyyy If unknown, indicate estimate mm dd yyyy

INFORMATION ABOUT THE CONDITION(S) CAUSING YOUR DISABILITY

What is the condition causing your disability?	What date did your symptoms first appear? mm dd yyyy
Describe your symptoms.	Date you were first treated by a physician for this condition mm dd yyyy

Prior to this disability claim, did you receive a diagnosis, medical care, including hospitalization, treatment, surgery, or advice and recommendation for the condition on this claim? Yes ☐ No ☐ If "Yes," please explain.

Is your condition or injury related to your employment? Yes ☐ No ☐ If "Yes," please explain.

Have you filed a Workers' Compensation Claim? Yes ☐ No ☐
If "No," do you intend to file a Workers' Compensation Claim? Yes ☐ No ☐

If your claim was approved or denied by the Workers' Compensation carrier, please provide a copy of the approval or denial letter along with your disability claim.

FOR AN INJURY OR ACCIDENT, ANSWER THE FOLLOWING QUESTIONS

Is your disability the result of an injury or accident? Yes ☐ No ☐

If "Yes" how and where did the injury/accident occur? _____

Is it Auto related? Yes ☐ No ☐

Date the accident occurred ____ ____ ____ (mm dd yyyy) Date you were first treated by a physician or other provider ____ ____ ____ (mm dd yyyy)

FOR PREGNANCY, ANSWER THE FOLLOWING QUESTIONS

What is your expected delivery date? ___ __ ____ (mm dd yyyy) Have you delivered? Yes ☐ No ☐ If "Yes," date of delivery ____ ___ ____ (mm dd yyyy)

Type of delivery Normal ☐ C-Section ☐

a) Were there any complications causing you to stop work prior to your expected delivery date? Yes ☐ No ☐

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

c) If "Yes" to either question, please explain.

INFORMATION ABOUT TREATING PROVIDER(S)

Provide the following information on all your medical treatment providers (physician, hospital, therapists, etc.) for this disability, including any referring physician and specialist. If needed, attach a separate sheet of paper.

(1) Provider Name Address

Specialty Fax No. Telephone No.

Date of first visit for this condition ___ __ ____ (mm dd yyyy) Date of most recent visit for this condition ___ __ ____ (mm dd yyyy)

(2) Provider Name Address

Specialty Fax No. Telephone No.

Date of first visit for this condition ___ __ ____ (mm dd yyyy) Date of most recent visit for this condition ___ __ ____ (mm dd yyyy)

Please list any hospital admissions, surgery, or treatment that you have had in the past 12 months, along with the diagnosis.

Type of Service	Provider/Facility name	Date(s) of service	Diagnosis
		___ __ ____ (mm dd yyyy)	
		___ __ ____ (mm dd yyyy)	
		___ __ ____ (mm dd yyyy)	

Provide a short written summary on your history of illness/injury, past medical history, examination results, lab results, diagnosis, prognosis, medical recommendations and any treatment dates or surgery not mentioned above.

OTHER INSURANCE

Do you have disability insurance other than insurance provided by Amalgamated Life Insurance Company? Yes ☐ No ☐

If "Yes," indicate type of coverage and name of policy or insurer.

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.

CLAIMANT CERTIFICATION

I HEREBY CLAIM DISABILITY AND CERTIFY THAT FOR THE PERIOD COVERED BY THE CLAIM I WAS DISABLED; AND THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.

	Claimant Name (Print)	**Signature**	**Date**
▶	_____	_____	___ __ ____ mm dd yyyy

IF I RECEIVE A DISABILITY BENEFIT GREATER THAN THAT WHICH I SHOULD HAVE BEEN PAID, I UNDERSTAND THAT AMALGAMATED LIFE INSURANCE COMPANY HAS THE RIGHT TO RECOVER SUCH OVERPAYMENTS FROM ME, INCLUDING THE RIGHTS TO REDUCE OR ADJUST FUTURE BENEFITS, IF ANY.

	Claimant Name (Print)	**Signature**	**Date**
▶	_____	_____	___ __ ____ mm dd yyyy

AUTHORIZATION TO RELEASE INFORMATION

Read, sign and date the Authorization for Release of Health Care Information Pursuant to HIPAA on page 5, and provide a copy to your treating physician. Submit a copy to Amalgamated Life Insurance Company along with your claim.

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.