P.O. Box 14294
Lexington, KY 40512-4294
Telephone: (877) 604-0077
Fax: (855) 864-0530

Alabama Education Association Disability Plan
Instructions for Filing Claims

Dear Insured:

Boston Mutual is pleased to provide you coverage when you are unable to work due to a covered disability. We have included these instructions and the necessary forms to assist you in the event you need to file a claim for disability benefits. Please remember that all forms must be received within 90 days of the date you stop work.

Employee Statement

1. Complete the Employee Statement in full.
2. Answer all questions or state "not applicable".
3. Review the attached Fraud Statement as it applies to your state of residence, sign and date.
4. Sign and date the Authorization forms.

Employer & Attending Physician Statements

1. Obtain the statement of your Attending Physician who will certify your disability.
2. Obtain the statement of your Employer.

Return All Forms to Boston Mutual Disability Claim Department:

Facsimile: (855) 864-0530

Mail: P.O. Box 14294, Lexington, KY 40512-4294

For Questions or Assistance Call or Contact Boston Mutual:

Telephone: (877) 604-0077

Attention: Disability Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Telephone: (877) 604-0077
Fax: (855) 864-0530

Statement of Claim
Alabama Education Association Disability Plan
Income Benefits
Employee's Statement

Instructions

1. **Please type or print in blue or black ink.**
2. **Please make sure all s on Employee's Statement are completed in full.**
3. **Employer's and Physician's Statements must be completed.**
4. **Authorization and Fraud Notice must be signed and currently dated.**
5. **Email, fax or mail the completed form to Boston Mutual Life Insurance Company.**

EMPLOYEE'S STATEMENT

Full Name (First, Middle, Last)	Social Security Number	Gender ☐ Male ☐ Female
Street Address	Date of Birth	Occupation
City, State, Zip	Telephone Numbers Home / Work	
Claim is for ☐ Accident ☐ Sickness ☐ Pregnancy	Nature of Accident or Sickness	

Date of 1st Treatment	Physician or Hospital First Treated By	First Full Day of Disability

If accident, how did the accident occur? _____

Accident Date _____ Time _____ ☐ A. M. ☐ P.M. Place _____

Was a third party responsible for accident? ☐ Yes ☐ No If Yes, third party's name _____

Third party's address _____

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement) ☐ Yes ☐ No $_____ Mo. V.A. Benefits: ☐ Yes ☐ No $_____ Mo.
Dependent Social Security: ☐ Yes ☐ No $_____ Mo. Worker's Compensation: ☐ Yes ☒ No $N/A Wk.
Retirement: (normal, early or disability) ☐ Yes ☐ No $_____ Mo. Other Disability Coverage: ☐ Yes ☐ No $_____ Wk.
Unemployment: ☐ Yes ☐ No $_____ Wk. (identify)_____

Include a copy of your award or denial letter for any source in which one has been received.

Names and addresses of all doctors consulted for **this** condition (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code

Have you ever had this or similar condition before? ☐ Yes ☐ No If yes, give particulars: Date _____

Describe_____

Names and addresses of all doctors seen for **any** condition in the past five years (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition

Attention: DisabilityClaims Department
P.O. Box 14294
Lexington, KY 40512-4294
Telephone: (877) 604-0077
Fax: (855) 864-0530

Statement of Claim
Alabama Education Association Disability Plan
Income Benefits
Attending Physician's Statement

Instructions

1. **Physician certifying disability must complete all questions, sign and date this Attending Physician's Statement.**
2. **Fax or mail the completed form to Boston Mutual Life Insurance Company.**

ATTENDING PHYSICIAN'S STATEMENT

Neither the Employee nor the Employer should complete or alter any part of this statement.

Patient's Full Name (First, Middle, Last)	Date of Birth

Diagnosis & Concurrent Conditions	ICD Codes
1.	1.
2.	2.

Disability is due to
☐ Accident ☐ Sickness ☐ Pregnancy
If accident, provide how, when and where accident occurred _____
_____
_____

If Pregnancy, _____ ☐ Actual ☐ Estimated
Delivery Date
Date of LMP _____
Type of Delivery ☐ Vaginal ☐ C-section
_____

Date Symptoms First Appeared _____
Date Patient First Consulted You _____
Dates & Surgical Procedures (if any) _____
_____
_____

If hospitalized, ☐ Inpatient ☐ Outpatient
Date Admitted_____ Date Discharged _____
Full Name of Hospital _____
Address _____
City, State, Zip Code _____
_____
Telephone # of Hospital _____

Is Disability due to injury or sickness arising out of or in the course of patient's employment? ☐ Yes ☐ No
_____

How long was or will patient be unable to work due to disability?
From _____ Through _____
Can return to work on _____
Please list all treatment dates during the month in which the disability began _____
_____

Date of next doctor's appointment _____

List Restrictions and Limitations_____
_____
_____
_____

Has patient ever had same or similar condition?
☐ No ☐ Yes Date _____

Describe any circumstances causing disability to be prolonged:

Physician's Signature	Date
Physician's Name (Please Print/Type)	Degree
Address	Telephone
City State Zip Code	Fax

FRAUD WARNING: Except as noted in the Fraud Notice, 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.

Attention: Disability Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Telephone: (877) 604-0077
Fax: (855) 864-0530

Statement of Claim
Alabama Education Association Disability Plan
Income Benefits
Employer's Statement

Instructions

1. **Employer must complete all questions, sign and date this Employer's Statement.**
2. **Fax or mail the completed form to Boston Mutual Life Insurance Company.**

EMPLOYER'S STATEMENT

Employee Name (First, Middle, Last)		Date of Birth	Social Security Number
Group Policy Number D03991	Date of Hire	Coverage Effective Date	Monthly LTD Benefit $

Last Day Worked	Date Returned to Work	Base Salary $ _____
Date _____ # of Hours _____	☐ Full-Time _____ ☐ Part-Time_____	☐ Hourly ☐ Monthly ☐ Weekly ☐ Annually

Employee Regularly Works _____ Hours Per Week	Employee's Occupation

Check Days Normally Worked?	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat

If on rotation, give number of days worked per week: _____

Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? ☐ Yes ☐ No

If yes, Status of claim? ☐ Pending ☐ Approved ☐ Denied ☐ Denial on Appeal

Name of Worker's Compensation Carrier: _____

Address of Worker's Compensation Carrier: _____

_____

Employee received: Salary continuation through _____ Vacation pay through _____ Sick pay through _____

Employer Name	Email address	Tax ID #
Signature	Title	Date
Name (Please print or Type)	Telephone	Fax

Street Address City State Zip Code

FRAUD WARNING: Except as noted in the Fraud Notice, 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.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period BML has approved my disability claim, I must report all details to BML, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. BML has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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 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.

For Residents of 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.

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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 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 a statement of claim or 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, 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 and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and 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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil 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 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.

For residents of Oregon: 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.

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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the 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 may have violated the state law.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Insured's Name (*Please print*) | Date of Birth | Last 4 Digits of Social Security Number

I AUTHORIZE ANY health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes**. I also authorize MIB, Inc. (formerly known as the Medical Information Bureau, Inc.), to provide protected health information.

By my signature below, **I acknowledge that any agreements the person named above has made to restrict protected health information. do not apply to this authorization**, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

I ALSO AUTHORIZE ANY health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration to disclose to BML a complete copy of any and all of the following personal or privileged information, records, or documents relative to the person named above:

Any and all work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to BML at:
Boston Mutual Life Insurance Company, Disability Claim Department, P. O. Box 14294 Lexington, KY 40512-4294.

I UNDERSTAND that once My Information has been disclosed to BML as permitted under this Authorization, it may be re-disclosed by BML as permitted by law or my further authorization. I authorize BML to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures BML may make, unless BML has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to BML. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing BML to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. I acknowledge that I have received a copy of BML's Notice of Information Privacy Practices. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian or Personal Representative | Date | Relationship to Insured (if signed by Guardian or Personal Representative)

Consumer Report Authorization

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my claim may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my claim, I will be informed by Boston Mutual of my rights, concerning that action. This authorization will be valid for twelve (12) months, or, if approved, the duration of my claim, whichever is greater.

_____ _____

Claimant Name printed Date

_____

Claimant Signature