

Phone Number: (866) 628-2606
Fax: (972) 996-9361

NOTE: All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

APPLICATION FOR LTD BENEFITS — Employee's Instructions

A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Fort Dearborn Life or its representative to secure additional information if necessary to make a decision on your claim.

B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

A. Attach:

- A copy of your birth certificate (only if disability is indefinite and you are over age 50)
- A copy of Social Security and other income entitlement awards; and

B. Return with all attachments, to Fort Dearborn Life at address above.

ATTENDING PHYSICIAN'S STATEMENT (APS) — Physician's Instructions

As soon as the claimant gives you this form:

A. Complete the APS on page 4 of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.

B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

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. (Not enforceable in Oregon or Virginia.)

C L A I M A N T	1. Full Name (Last, First, Middle Init.)		2. Maiden Name		3. Alias Name		4. Benefits ID No.		5. Phone Number () () ()					
	6. Address			City			State			Zip Code				
	7. Date of Birth Mo. Day Year		8. Height ft. in.		9. Weight lbs.		10. Sex <input type="checkbox"/> M <input type="checkbox"/> F		11. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Spouse's date of birth Mo. Day Year First Name		13. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	14. Number of children (Under age 19)				15. List names and dates of birth of unmarried children who have not finished high school.									
E M P L O Y M E N T	16. Employer's Name						17. Group Policy No.							
	18. Occupation (List the duties of your occupation at the time of disability)													
	19. Date of accident or date first noticed symptoms of illness: Mo. Day Year			20. I have been unable to work because of the disability since: Mo. Day Year			21. I returned to work on a part time basis on: Mo. Day Year			22. I returned to work on a full time basis on: Mo. Day Year				
	23. Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No				24. Have you or do you intend to file a Workers' Comp. Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," explain									
C L A I M H I S T O R Y	25. Describe how and where accident occurred or describe the onset and nature of your illness.													
	26. Date you were first treated for your illness or injury. Mo. Day Year			27. Treated by: Hospital: _____ Name Street Address City State Zip Code Doctor: _____ Name Street Address City State Zip Code										
	28. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete No. 29.			29. Treated by: Hospital: _____ Name Street Address City State Zip Code Doctor: _____ Name Street Address City State Zip Code										
	30. Describe other income you are receiving:													
O T H E R I N C O M E	Yes		No		Type		Date Amount		Date Began		Term.			
	<input type="checkbox"/>	<input type="checkbox"/>	Social Security (disability or retirement)		\$ _____		_____		_____					
	<input type="checkbox"/>	<input type="checkbox"/>	State disability		\$ _____		_____		_____					
<input type="checkbox"/>	<input type="checkbox"/>	Retirement (normal, early or disability)		\$ _____		_____		_____		_____				
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation		\$ _____		_____		_____		_____				
<input type="checkbox"/>	<input type="checkbox"/>	Group disability benefits		\$ _____		_____		_____		_____				
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____		\$ _____		_____		_____		_____				
31. Have you applied, or do you plan to apply for benefits described above? <input type="checkbox"/> Yes <input type="checkbox"/> No														
Type _____			Date application filed _____			Type _____			Date application filed _____					
32. If your request for benefits is approved, do you want us to withhold amounts from each benefit for Federal Income Tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete and attach IRS Form W4S.														
<p>AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Fort Dearborn Life Insurance Company's (FDL) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim.</p> <p>This authorization expires on the date I receive notice of FDL's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation. Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from FDL. If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny my claim.</p> <p>Signature of Employee _____ Date _____</p>														

Attending Physicians Statement

Name of patient		Date of Birth	* Please submit bill for records with this claim.
HISTORY	(a) When did symptoms first appear or accident happen?	(b) Date patient ceased work because of disability?	(c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes If "Yes" state when and describe <input type="checkbox"/> No
	(d) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(e) Names and addresses of other treating physicians	
DIAGNOSIS	(a) Diagnosis (Including complications) Please submit all office notes in regard to this condition*		(b) Subjective symptoms
	(c) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings?)		
TREATMENT	(a) Date of first visit	(b) Date of last visit	(c) Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)
	(d) Nature of treatment (Including surgery and medications prescribed, if any)		
PROGRESS	(a) Has patient <input type="checkbox"/> Recovered? <input type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?	(b) Is patient <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?	
	(c) Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from _____ through _____ If, yes, give Name and Address of Hospital:		
CARDIAC	(a) Functional capacity (American Heart Ass'n.) <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation)		(b) Blood Pressure (last visit) _____ systolic/diastolic
	(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles). <input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity* (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%) Remarks:		
IMPAIRMENT	(b) Mental Impairments (If applicable)		
	(a) Please define "stress" as it applies to this claimant. (b) What stress and problems in interpersonal relations has claimant had on job? <input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks:		
PROGNOSIS	(a) Is patient now totally disabled? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Date patient became disabled due to present illness
	(c) When do you expect a fundamental or marked change in the future? <input type="checkbox"/> 1 Mo. <input type="checkbox"/> 1-3 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> Never. Applies To: <input type="checkbox"/> Patient's job <input type="checkbox"/> Other Work		
REHAB	(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB <input type="checkbox"/> Yes <input type="checkbox"/> No ANY OTHER WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Can present job be modified to allow for handling with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) When could trial employment commence? Date _____ PATIENT'S JOB <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date _____ ANY OTHER WORK <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
REMARKS	(Limitations, Therapy, etc.)		
Name (Attending Physician) <i>Print</i>		Degree	Telephone () Fax #: ()
Street Address		City or Town	State Zip Code
Signature		Date	

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

The laws of some states require us to furnish you with the following notice:**FOR APPLICATIONS AND CLAIMS:**

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.

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.

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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: 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 commits a fraudulent insurance act, which is a crime.

Louisiana: 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 & 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.

Maryland: Any person who knowingly and willingly 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.

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.

Ohio: Any person who, with intent to defraud or knowingly 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: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

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.

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 with the penalty of 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 are 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.

Rhode Island: 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.

Tennessee: 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

Virginia: 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.

The laws of some states require us to furnish you with the following notice:**FOR CLAIMS ONLY:**

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: 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.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing 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.

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.

Texas: 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.

FOR APPLICATIONS ONLY:

Massachusetts: 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.

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.