

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The *Policyholder* can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

Written Proof of Loss

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the *Policyholder* and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the *Proof of Disability* provision.

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 91 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is shown in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 91 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1. It was not reasonably possible to give written proof during the 1 year period, and
2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to provide complete proof of loss may delay, suspend or terminate *Your* benefits.

1. The date *Your Disability* began;
2. The cause of *Your Disability*;
3. The prognosis of *Your Disability*;
4. Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5. Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6. The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7. Appropriate documentation of *Your Monthly Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8. If *You* were contributing to the premium cost, the *Policyholder* must supply proof of *Your* appropriate payroll deductions.
9. The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10. If applicable, proof of incurred costs covered under other benefit provisions in the Policy.

Continuing Proof of Disability

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be made as often as reasonably necessary, but not more frequently than once every 3 months. If required, this will be at *Your* expense and must be received within 45 days of *Our* request. Failure to comply with such a request may delay, suspend or terminate *Your* benefits.

Examination

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may result in denial, suspension or termination of benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* will be asked to supply

1. *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information in support of *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2. *You* will be required to supply proof that *You* have applied for other Deductible Sources of Income such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3. *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Sources of Income. *You* must tell *Us* the nature of the Deductible Source of Income, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

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Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit on a monthly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your*: 1) *Spouse*; 2) children including legally adopted children; 3) parents; or 4) *Your* estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to \$1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

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Can *You* assign *Your* benefits?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

What will happen if a claim is overpaid?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs. The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.

We have the right to recover from *You* any amount that is an overpayment of benefits under the Policy. *You* must refund to us the overpaid amount. *We* may also, without forfeiting our right to collect an overpayment through any means legally available to *Us*, recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the *Minimum Monthly Benefit*.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery. If *LTD Monthly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the minimum *LTD Monthly Benefits* payable under the Policy.

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*. *We* will bear any expenses associated with *Our* pursuit of subrogation or recovery.

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