Dearborn National®
Life Insurance Company of New York

Home Office: Pittsford, New York
Phone Number: (800) 778-2281
Fax: (312) 540-4706

Group Life Waiver of Premium Claim Form

Return to Dearborn National at:
Attention: Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

INSTRUCTIONS

A Waiver of Premium claim should be filed for an eligible insured who has been continuously disabled for the length of time indicated in the policy (the waiver elimination period - usually six or nine months). However, the claim may be submitted prior to that time if it can be presumed that the employee will remain continuously disabled for the required amount of time.

Premium must continue to be paid during the waiver elimination period.

To be eligible for Waiver of Premium, the eligible employee must be under the age of sixty, or age specified in the policy, on the date their disability begins.

Please Note: Proof of disability must be received within one year of the start of the disability.

Please submit the following documentation:

1. Claim Form:

   Part 1 – Completed by the Employer/Administrator
   Part 2 - Completed by the Insured, or if deceased, by his/her Spouse, Registered Domestic Partner or Legal Representative.
   Part 3 – Completed by the Attending Physician (insured is responsible for any costs)

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.

3. If the benefits are based on salary, submit payroll records verifying the employee's annual earnings at the time of their death.

4. If any portion of coverage is paid for by the employee, submit proof of payroll deduction.

5. The insured person is responsible for any costs associated with completion of the Attending Physician Statement.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company of New York (Pittsford, NY).

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Part 1 – To be completed by Employer/Administrator

Statement of Employer

Employer/Plan Information

Group Name ______________________ Subsidiary Name ______________________

Group Number ______________________

Address: ______________________ ______________________ ______________________
Street City State/Zip

Name and Title of Authorized Representative ______________________

Phone Number ______________________ Fax Number ______________________

E-Mail Address ______________________

Insured Person Information

Name of Claimant ______________________

Social Security No. ______________________ Date of Birth ______________________

Address: ______________________ ______________________ ______________________
Street City State/Zip

Hire Date ____________ Insurance Effective Date ____________ Occupation ____________

Annual Salary ______________________ Date of Last Salary Increase ______________________

Amount of Insurance: Basic Life ____________
Supplemental Life ____________
Voluntary Life ____________

Last Day Worked ____________ Reason for cessation of work: ______________________

Provide date of disability ______________________

If the eligible insured is deceased provide proof that he/she died within one year from the date of becoming Totally Disabled, and remained Totally Disabled until the date of death.

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.

Signature of Authorized Employer/Plan Representative ______________________

Print Name ______________________ Date______________________

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Part 2 – To be completed by Insured or if deceased, by his/her Spouse, Registered Domestic Partner or Legal Representative.

Name ______________________________
Last First Middle

Maiden Name ____________________ Alias Name ____________________

Date of Birth ____________ HT ______ WT ______ Social Security No. ____________

Address ______________________________
Street City State Zip

Phone ____________________ E-mail ____________________

Are you a U.S. Citizen: ❑ Yes ❑ No (If No – IRS Form W-8 required)

Date of Accident or beginning of sickness ____________________

If Injury, describe how, when and where accident occurred: ____________________

____

If Illness: have you ever had same or similar illness? ❑ Yes ❑ No If yes, give dates: ____________

Name of Employer ____________________ Last day worked ____________

Occupation ____________________

Between what dates were you unable to perform any duties? ____________________

Name of Treating Physician ____________________ Phone Number ____________
(If multiple physicians, please list all. Attach a separate page if necessary)

Location of Treating Physician ______________________________
Address City State Zip

Name of Hospital where treatment was received ____________________
(If multiple hospitals, please list all. Attach a separate page if necessary)

Location of Hospital ______________________________
Address City State Zip

Hospital Phone Number ____________________

Admission Date ____________________ Discharge Date ____________________

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Your Signature ______________________________ Date ____________________

Printed Name ______________________________

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Part 3 – Attending Physician's Statement
(Insured is responsible for any costs associated with completion of the Attending Physician's Statement)

Name of Patient ________________________ Gender __________ Date of Birth ______________

Address ____
Street City State Zip

Date of Accident or appearance of symptoms ______________________________

Date First Consulted ______________ Date of Total Disability Diagnosis ______________

Date of Permanent Disability Diagnosis ______________

Has patient ever had same or similar conditions? ______________________________

Is the disability the result of an accident? ❑ Yes ❑ No

If Yes, please list any co-morbid conditions contributing to the disability.
____
____

Diagnosis/ICD 9/10 ______________

Is patient still under your care? ❑ Yes ❑ No Last Date of Treatment ______________

Patient can return to work on ______________ Full/Time ❑ Yes ❑ No Part/Time ❑ Yes ❑ No
# of hrs per day_____week______

Patient disabled (unable to work) Own Occupation _____ Any Occupation _____

Patient permanently disabled Own Occupation _____ Any Occupation _____

Symptoms ____

Treatment ____

Medications ____

Limitations/Restrictions ____

Specialist Referral to ____

Physician Name ________________________ Specialty ______________

Address ____
Street City State Zip

Telephone ______________ Fax ______________ EIN/SSN ______________

Signature________________________________ Date ______________

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AGREEMENTS AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize my employer to disclose all information necessary to process my claim to Dearborn National® Life Insurance Company of New York (Dearborn National NY).

I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn National NY's claim department or its authorized representative(s) information about my medical history or treatment and/or 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 and mental illness. I further authorize Dearborn National NY to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

This authorization shall expire on the date that I received notice of Dearborn National NY's final decision on my claim. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by Dearborn National NY 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;
- I should retain a copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from Dearborn National NY.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, Dearborn National NY has the right to deny my claim.

WARNING: 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 materials 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.

SIGNATURE: ____ DATE: ____________________

Print Name: ____

Claimant/Legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured or personal/legal representative signing for Claimant/Insured:

ADDRESS: ____ PHONE NO. ____________________
Street

____
City State Zip

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