Leaders Life Insurance Company
Disability Services Division
P.O. Box 86
Bloomfield, CT 06002
(888) 342-7979

PLEASE ANSWER ALL QUESTIONS FULLY AS THIS WILL HELP EXPEDITE THE EVALUATION OF YOUR CLAIM. INSTRUCTIONS: INSURED: COMPLETE PART I, SIGN AND DATE THE AUTHORIZATION FOR RELEASE OF INFORMATION, THE FRAUD STATEMENT, AND THE CLAIMANT'S OCCUPATIONAL DESCRIPTION. HAVE YOUR PHYSICIAN COMPLETE PART II AND YOUR EMPLOYER COMPLETE PARTIII AND RETURN ALL DOCUMENTS TO THE CLAIM ADMINISTRATOR.

MAIL TO:	Leaders Life Insurance Company, Disability Services Division, P. O. Box 86, Bloomfield, CT 06002 or FAX to 860-761-1801 (with originals to follow)

PART I -- INSURED'S STATEMENT

POLICY NUMBER		☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER)
NAME OF INSURED	DATE OF BIRTH _____/_____/_____		

INSURED'S ADDRESS (Home Address)	CITY	STATE	ZIP CODE
INSURED'S ADDRESS (Mailing address if different)	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER		
NAME OF EMPLOYER	EMPLOYER TELEPHONE NUMBER		
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

THE BUSINESS ENTITY IS A (if self-employed) ☐ CORPORATION ☐ SUB CHAPTER S ☐ PARTNERSHIP ☐ SOLE PROPRIETORSHIP

WHAT IS YOUR OWNERSHIP PERCENTAGE? _____%

OCCUPATION	SPECIALTY (if applicable)

WEEKLY EARNED INCOME AT THE TIME YOUR TOTAL DISABILITY BEGAN: (Please submit most recent pay stub) GROSS $ _____ NET $ _____

AVERAGE WEEKLY EARNED INCOME DURING THE TWO YEARS JUST PRIOR TO DISABILITY: $ _____ $ _____
(Please submit personal and business tax returns for the applicable years with all supporting attachments and schedules)

DATE ACCIDENT OR SICKNESS BEGAN	DATE LAST WORKED	DATE FIRST TREATED BY PHYSICIAN FOR PRESENT DISABILITY
NATURE OF SICKNESS OR INJURY		DID DISABILITY ARISE OUT OF EMPLOYMENT? YES NO

IF INJURED, HOW, WHEN AND WHERE DID THE ACCIDENT HAPPEN? (Please include a copy of any police or incident report)

DATE TOTAL DISABILITY COMMENCED	IF RECOVERED, GIVE DATE OF RECOVERY

DATE OF YOUR RETURN TO WORK FULL TIME____/____/____ (____) HOURS PER DAY PART TIME____/____/____ (____) HOURS PER DAY

NAME AND ADDRESS OF ALL PHYSICIANS AND/OR FACILITIES TREATING YOU FOR THIS CONDITION (Attach additional sheet of paper if necessary)

HAVE YOU APPLIED AND/OR ARE YOU ENTITLED TO BENEFITS FROM ANY OF THE FOLLOWING FOR THIS DISABILITY?

☐ WORKERS' COMPENSATION ☐ ANY GOVERNMENT AGENCY ☐ OTHER INSURANCE BENEFITS
☐ SOCIAL SECURITY ☐ LOCAL, STATE, OR NATIONAL ASSOCIATION OR SOCIETY DISABILITY INCOME PLAN
☐ SALARY CONTINUANCE ☐ NONE

IF "YES", LIST POLICY NUMBER, NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS OR SERVICES AND AMOUNT OF PAYMENT.

POLICY NUMBER	NAME, ADDRESS AND PHONE NUMBER	DATE OF APPLICATION	AMOUNT OF PAYMENT
		____/____/_____	$
POLICY NUMBER	NAME, ADDRESS AND PHONE NUMBER	DATE OF APPLICATION	AMOUNT OF PAYMENT
		____/____/_____	$

I HEREBY CERITFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF INSURED	DATE

PART II -- ATTENDING PHYSICIANS'S STATEMENT (attach additional pages as needed)
(TO BE COMPLETED BY PHYSICIAN WITHOUT EXPENSE TO THE COMPANY

NAME OF PATIENT	HEIGHT	WEIGHT	BLOOD PRESSURE /	DATE OF BIRTH / /

HISTORY
When did symptoms first appear or accident happen? ..... Mo. _____ Day _____ Year _____
Date patient was unable to work because of disability? ..... Mo. _____ Day _____ Year _____
Has patient ever had same or similar condition? ..... ☐ Yes ☐ No If Yes, when? Mo. _____ Day _____ Year _____
Pregnancy? ☐ Yes ☐ No If "Yes", what is the estimated date of delivery? _____ Actual date of delivery? _____
Names and addresses of other treating physicians _____

DIAGNOSIS (including any complications) _____
Subjective symptoms _____
_____
Objective findings (including current X-rays, EKG's, Laboratory Data, and any clinical findings) _____

DATES OF TREATMENT Date of first visit____/____/____ Date of last visit____/____/____ Date of next visit____/____/____

NATURE **OF TREATMENT (**Include surgery, date and description, and medications prescribed, if any)

PROGRESS
Patient has ..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
Patient is ..... ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined
Has patient been hospital confined? ☐ Yes ☐ No If Yes, Name of Hospital _____
Address _____ Confined from _____ through _____

CARDIAC (If applicable) Functional Capacity (American Heart Association)
☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
Blood Pressure _____/_____ as of _____ date

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupation Titles)
☐ Class 1 -- No Limitation of functional capacity; capable of heavy work.* No restrictions. (0 --10%)
☐ Class 2 -- Medium limitation of function capacity; manual activity. * (15 -- 30%)
☐ Class 3 -- Slight limitation of functional capacity; capable of light work.* (35 -- 55%)
☐ Class 4 -- Moderate limitation of functional capacity; capable of clerical./administrative (sedentary*) activity. (60 -- 70%)
☐ Class 5 -- Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75 -- 100%)

MENTAL/NERVOUS IMPAIRMENT
☐ Class 1 -- Patient is able to function under stress and engage in interpersonal relations. (no limitations)
☐ Class 2 -- Patient is able to function in most stress situations and engage in most interpersonal relations. (slight limitations)
☐ Class 3 -- Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. (moderate limitations)
☐ Class 4 -- Patient is unable to engage in stress situations or engage in interpersonal relations. (marked limitations)
☐ Class 5 -- Patient has significant loss of psychological, personal and social adjustment. (severe limitations)

COMPETENCY
Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

PROGNOSIS
What are the patient's restrictions and limitations?

	PATIENT'S JOB	**ANY OTHER WORK**
If no restrictions and limitations, when was patient able to resume work?	Mo. _____ Day _____ Year _____	Mo. _____ Day _____ Year _____
Do you expect a fundamental or marked change in the future including ☐ improvement and/or ☐ deterioration?	☐ Yes ☐ No	☐ Yes ☐ No
When will patient recover sufficiently to perform duties?	☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Indefinitely ☐ Never	☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Indefinitely ☐ Never

ADDITIONAL CARE Have you referred your patient for other types of consultation? ☐ Yes ☐ No
If Yes, Name and Address: _____
Specialty: _____

I HEREBY CERITFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

NAME OF PHYSICIAN COMPLETING THIS FORM (PRINT)	DEGREE/SPECIALTY		TAX ID NUMBER
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		
SIGNATURE OF PHYSICIAN COMPLETING THIS FORM			DATE

PLEASE RETURN THIS FORM TO THE INSURED OR THE ADMINISTRATOR

PART III -- EMPLOYER'S STATEMENT (attach additional pages as needed)

PLEASE PROVIDE A COPY OF THE OCCUPATIONAL DESCRIPTION APPLICABLE TO EMPLOYEE

NAME OF EMPLOYEE	OCCUPATION	IS DISABILITY DUE TO EMPLOYMENT? ☐ Yes ☐ No	AVERAGE NUMBER OF HOURS WORKED PER WEEK

SALARY

	Gross	Net
Weekly earned income at time disability began	$_____	$_____
Average weekly earned income for two years prior to the date of disability	$_____	$_____

DATE EMPLOYED	DATE INSURED	DATE LAST WORKED	REASON FOR STOPPING WORK	Effective Date ____/____/_____
____/____/_____	____/____/_____	____/____/_____	☐ Dismissed ☐ Lv of Absence ☐ Disability ☐ Resigned ☐ Retired ☐ Layoff	

DATE RETURNED TO WORK	IF EMPLOYEE HAS NOT RETURNED TO WORK, APPROXIMATE RETURN TO WORK DATE	DATE EMPLOYMENT TERMINATED
☐ FULL-TIME ☐ PART-TIME NUMBER OF HOURS ____/____/_____ ____/____/_____ _____	____/____/_____	____/____/_____

WERE THERE ANY CHANGES TO THE EMPLOYEE'S JOB RESPONSIBILITIES DUE TO THE DISABLING CONDITION BEFORE THE EMPLOYEE BECAME TOTALLY DISABLED? ☐ Yes ☐ No IF YES, WHAT WERE THE CHANGES AND WHEN WERE THEY MADE?

IS THIS EMPLOYEE ELIGIBLE FOR SALARY CONTINUATION? ☐ Yes ☐ No
Please include a copy of applicable payroll record(s)
IF "YES", WHAT IS THE WEEKLY AMOUNT? $_____ WHEN DO BENEFITS BEGIN? ____/____/____ END? ____/____/____

CHECK THE ITEMS BELOW THAT RELATE TO THE EMPLOYEE'S JOB AND COMPLETE THE INFORMATION REQUESTED.
USE THESE DEFINITIONS FOR THE FREQUENCY OF OCCURRENCE:

Not applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	N/A	Occasionally	Frequently	Continuously
Standing				
Walking				
Balancing				
Stooping				
Kneeling				
Crouching				
Crawling				
Reaching/working overhead				
Keyboard Use/Repetitive Hand Motion				
Climbing				

Activity	Frequency	Weight
○ PUSHING	_____	_____LBS.
○ PULLING	_____	_____LBS.
○ LIFTING	_____	_____LBS.
○ CARRYING	_____	_____LBS.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

_____ NAME OF POLICYHOLDER (COMPANY)

_____ PRINT NAME &TITLE OF OFFICAL REPRESENTATIVE

_____ MAILING ADDRESS OF POLICYHOLDER (COMPANY)

_____ SIGNATURE

_____ TELEPHONE NUMBER

_____ FAX NUMBER

_____/____/_____ DATE

PLEASE RETURN THIS FORM TO LEADERS LIFE INSURANCE COMPANY, P.O. Box 86, Bloomfield, CT 06002

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Authorization for Release of Information
HIPAA Compliant

CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby authorize all of the people and organizations listed below to give Leaders Life Insurance Company and its authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information documents, treatment notes (including psychotherapy notes), consultation notes, and reports of diagnostic procedures relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.
- any and all information relating to my occupation, my employment, or my activities.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility
- any insurance or reinsurance company (including, but not limited to, the Recipient)
- any consumer reporting agency or insurance support organization;
- my employer, group policyholder, or benefit plan administrator; and
- the Medical Information Bureau (MIB); and
- any other person or business.

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for coverage and/or benefits under an insurance policy; and
- detect insurance fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance company listed above is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Leaders Life Insurance Company's Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: Leaders Life Insurance Company, P. O. Box 86, Bloomfield, CT 06002. I understand that my revocation of this authorization will not affect prior uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipient may not be able to obtain the information necessary to consider my claim for benefits.

I further understand an investigative consumer report may be requested concerning factors affecting my eligibility for insurance benefits. The factors which may be investigated include my activities, personal characteristics, mode of living, and health history. The report may be obtained through personal interviews with my friends, neighbors, and associates. I have a right to submit a written request to you for a complete and accurate disclosure of the nature and scope of any such report.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Name of Claimant (print) Date

_____ _____

Signature of Claimant/Guardian/Representative Description of Authority of Personal Representative (if applicable)

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Fraud Statement

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines, and denial of benefits.

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.

CALIFORNIA: For your protection California law requires the following to appear on this form: 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.

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 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 guilt of a felony of the third degree.

KENTUCKY: 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insured: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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 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.

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 state value of the claim for each such violation.

_____ _____
Signature of Insured Date

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Claimant's Occupational Description

Important: This form should be completed as fully as possible with respect to your work immediately prior to your claimed date of disability.

NAME OF INSURED		SOCIAL SECURITY NUMBER		DATE OF BIRTH
EMPLOYER NAME		EMPLOYER'S ADDRESS (City, State, Zip)		
EMPLOYER'S TELEPHONE NUMBER	NAME OF SUPERVISOR	YRS. WITH EMPLOYER	LAST DAY WORKED	IF OWNER, PERCENTAGE OWNERSHIP
HRS. WORKED PER WEEK	USUAL DAYS WORKED S M T W T F S	USUAL DAILY HOURS *From :*_____ *To:*_____	AVERAGE WEEKLY SALARY $ _____	YEARS IN OCCUPATION
OCCUPATION TITLE(S)				

A. Occupational Duties and Activities (List the most important first)

	Hrs. per Week	**% of Time**
1. Duty _____		
Description _____	_____	_____
2. Duty _____		
Description _____	_____	_____
3. Duty _____		
Description _____	_____	_____
4. Duty _____		
Description _____	_____	_____

B. Instruments, Tools or Equipment Normally used in Your Occupation: _____

C. Where Do You Work? ☐ Mostly Indoors ☐ Mostly Outdoors ☐ Equally In and Out

D. Travel (If your occupation normally requires travel other than between residence and principal place of business, describe usual frequency, mode of travel, trip distance and purpose.)

E. Professional Affiliations, Licenses, and Certifications (i.e. Trade Memberships, Associations):

_____

_____

Licenses and Certifications (Include License and/or Certification No.): _____

_____

_____
NAME OF CLAIMANT (PRINT)

_____ _____
SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE DATE

LDR OCCDESC