



**THE LAFAYETTE LIFE INSURANCE COMPANY**  
**1905 Teal Road, P. O. Box 7007**  
**Lafayette, Indiana 47903-7007**

9. Is patient a suitable candidate for a rehabilitation program?  Yes  No If "YES," please describe nature of rehabilitation which would benefit patient

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10. Is patient capable of managing his or her personal and financial affairs, including the endorsing of any checks and the giving of a release?

Yes  No If "no," please explain \_\_\_\_\_

11. If patient is unable to perform the substantial and material duties of his or her own occupation and/or any occupation, do you expect a marked change in the future?

Yes If so, when  No Why not? \_\_\_\_\_

12. Please describe the current course of treatment (including any surgery performed or anticipated and all medications or other treatment patient is presently receiving) \_\_\_\_\_

13. Date(s) patient was most recently hospitalized and name and address of hospital

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14. Any additional information you believe is relevant to our review

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**DATE:** \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Degree(s)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Specialties, if any, including any Board Certifications

\_\_\_\_\_  
Complete Mailing Address, including zip code

\_\_\_\_\_  
Telephone Number (including area code)

\_\_\_\_\_  
Fax Number (including area code)

\_\_\_\_\_  
E-mail Address (if applicable)



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7. Have you applied for social security disability benefits?     Yes                     No

If "Yes," please provide full details as to status of the claim and provide a copy of any award letter which may have been issued: \_\_\_\_\_

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8. How does your injury or sickness prevent you from performing the substantial and material duties of:

A. Your present occupation:

\_\_\_\_\_

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B. Any occupation:

\_\_\_\_\_

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9. On what date were you first prevented from working as a result of your injury or sickness:

\_\_\_\_\_

10. Have you worked anywhere since the date listed in 9, above, and the date you signed this form below?

Yes  No If "Yes," please provide full details of where you worked and the duties you performed: \_\_\_\_\_

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11. Are you now working anywhere?     Yes                     No                    If "Yes," please provide full details of where you are presently working, including the name and address of the entity and the duties you are performing:

\_\_\_\_\_

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If "Yes," please provide full details on the nature of the designation and license and current licensing status:

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9. List all languages that you speak fluently?

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WORK EXPERIENCE

1. Describe in full the duties of your present occupation:

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2. How long have you worked in your present occupation? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

3 Starting with the most recent job you held before your current occupation and working backward, please provide the following: **(PLEASE NOTE IS ROOM TO ENTER INFORMATION FOR UP TO SIX PRIOR JOBS. IF YOU NEED MORE SPACE, PLEASE ATTACH ADDITIONAL SHEETS)**

A. DATES EMPLOYED AT MOST RECENT JOB

FROM \_\_\_\_\_ TO \_\_\_\_\_

WHERE EMPLOYED (PLEASE PROVIDE FULL NAME AND ADDRESS. IF SELF-EMPLOYED, SO INDICATE):

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DUTIES/RESPONSIBILITIES/PHYSICAL REQUIREMENTS:

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B. DATES EMPLOYED AT NEXT MOST RECENT JOB

FROM \_\_\_\_\_ TO \_\_\_\_\_

WHERE EMPLOYED (PLEASE PROVIDE FULL NAME AND ADDRESS. IF SELF-EMPLOYED, SO INDICATE):

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DUTIES/RESPONSIBILITIES/PHYSICAL REQUIREMENTS:

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C. DATES EMPLOYED AT NEXT MOST RECENT JOB

FROM \_\_\_\_\_ TO \_\_\_\_\_

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WHERE EMPLOYED (PLEASE PROVIDE FULL NAME AND ADDRESS. IF SELF-EMPLOYED, SO INDICATE):

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DUTIES/RESPONSIBILITIES/PHYSICAL REQUIREMENTS:

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D. DATES EMPLOYED AT NEXT MOST RECENT JOB

FROM \_\_\_\_\_ TO \_\_\_\_\_

WHERE EMPLOYED (PLEASE PROVIDE FULL NAME AND ADDRESS. IF SELF-EMPLOYED, SO INDICATE):

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DUTIES/RESPONSIBILITIES/PHYSICAL REQUIREMENTS:

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E. DATES EMPLOYED AT NEXT MOST RECENT JOB

FROM \_\_\_\_\_ TO \_\_\_\_\_

WHERE EMPLOYED (PLEASE PROVIDE FULL NAME AND ADDRESS. IF SELF-EMPLOYED, SO INDICATE):

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DUTIES/RESPONSIBILITIES/PHYSICAL REQUIREMENTS:

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F. DATES EMPLOYED AT NEXT MOST RECENT JOB

FROM \_\_\_\_\_ TO \_\_\_\_\_

WHERE EMPLOYED (PLEASE PROVIDE FULL NAME AND ADDRESS. IF SELF-EMPLOYED, SO INDICATE):

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DUTIES/RESPONSIBILITIES/PHYSICAL REQUIREMENTS:

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**PART II – C**

**AUTHORIZATION TO RELEASE INFORMATION**

Insured's\* Full Name (**PLEASE PRINT**): \_\_\_\_\_

Claim No. (if known): \_\_\_\_\_ Policy Nos. \_\_\_\_\_

I authorize any: (1) licensed physician, (2) health care practitioner, (3) health care professional, (4) osteopath, (5) chiropractor, (6) hospital, (7) medical or mental clinic, (8) sanitarium, (9) other health care provider or other health care facility, (10) law enforcement agency, (11) coroner or medical examiner, (12) insurance company or affiliate or subsidiary of any insurance company, (13) third party administrator, (14) The Lafayette Life Insurance Company, (15) consumer reporting agency, (16) employer (whether past or present), (17) the Veteran's Administration, (18) Social Security Administration, and (19) the Medical Information Bureau (M.I.B., Inc.) that has any personal information, records (of any type or nature), health history or medically related knowledge of the Insured\* to release information about the Insured\* to the persons or organizations described below.

I authorize any such person or institution to release and give copies of all records, including records of health history, treatment, and diagnosis, and all reports, including reports of all present or past physical, mental or medically related conditions (including conditions or information occurring or in its hands after the date and during the validity of this authorization) concerning the Insured\* to the following persons or organizations: The Lafayette Life Insurance Company, its reinsurers, authorized claim representatives, insurance support organizations or investigating agents or agencies hired by The Lafayette Life Insurance Company or employees of The Lafayette Life Insurance Company who have been requested to secure such information.

I also authorize The Lafayette Life Insurance Company or its reinsurers or authorized claim representatives to release any information collected about the Insured to the Medical Information Bureau (M.I.B., Inc.) and to other insurance companies with whom I have policies or to whom I may apply for insurance.

I understand the information is needed for and will be used to evaluate a claim for insurance benefits. I further authorize The Lafayette Life Insurance Company to obtain an investigative consumer report on the Insured\*.

A photocopy of this Authorization shall be as valid as the original. This Authorization shall be valid for 24 months from the date signed. I understand that I may revoke this Authorization at any time by written revocation sent to the Claims Department of Lafayette Life at the above address. Revocation is effective upon receipt by The Lafayette Life Insurance Company, subject to the rights of an individual who acted in reliance on this Authorization prior to notice of the revocation.

I understand I am entitled to receive a copy of this Authorization on request.

By my signature below, I hereby certify that all the information contained in this Part II, Claimant's Statement of Claim, is true, correct and complete. I understand that The Lafayette Life Insurance Company will rely on this information in evaluating my claim for benefits. I further understand that the evaluation of this claim is subject to the terms of the group life insurance policy issued to the policyholder. I acknowledge that I have received and have read the attached **FRAUD WARNING**.

**DATE SIGNED:** \_\_\_\_\_

Signed Name

\_\_\_\_\_  
Witness' Signature (Agent, if present)

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Insured\* (if not Insured\*) \_\_\_\_\_

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**\*NOTE:** THE USE OF THE TERM "INSURED" IS FOR CONVENIENCE ONLY. THE USE OF THIS TERM DOES NOT CONSTITUTE ANY AGREEMENT OR ADMISSION THAT THE PERSON NAMED IS INSURED FOR COVERAGE UNDER THE APPLICABLE POLICY. THE TERMS OF THE POLICY WILL GOVERN COVERAGE.

**PART II - D  
FRAUD WARNING**

We are required by the laws of various states to include a fraud warning in connection with any claim form issued by The Lafayette Life Insurance Company. Listed below are the required warnings. Please refer to your state of residence , on the list below, for the appropriate warning.

**NOTICE TO CLAIMANTS WHO ARE RESIDENTS OF ANY OF THE FOLLOWING STATES:**

**ARKANSAS, LOUISIANA OR 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 FINES AND CONFINEMENT IN PRISON.

**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:** A PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**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.

**DELAWARE OR IDAHO:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**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.

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**FLORIDA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THIRD DEGREE.

**INDIANA:** A PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD AN INSURER FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**KANSAS:** ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATIONS OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

**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.

**MAINE OR 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**MINNESOTA:** A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELP COMMITS 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 CIVIL AND CRIMINAL PENALTIES.

**OHIO:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATION A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**OKLAHOMA:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY 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,

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INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**PART III – EMPLOYER'S STATEMENT**

**NAME OF POLICYHOLDER** \_\_\_\_\_

**POLICY NO.** \_\_\_\_\_ **EMPLOYER\*** \_\_\_\_\_

\* IF DIFFERENT THAN POLICYHOLDER

EMPLOYEE'S NAME: \_\_\_\_\_ SOC SEC NO. \_\_\_\_\_

CERTIFICATE NUMBER \_\_\_\_\_ EMPLOYEE'S DATE OF BIRTH: \_\_\_\_\_

EMPLOYEE'S DATE OF HIRE: \_\_\_\_\_ DATE ELIGIBLE FOR LIFE COVERAGE: \_\_\_\_\_

WAS EVIDENCE OF INSURABILITY REQUIRED? [ ] Yes [ ] No

If "Yes," please provide reason evidence was required and attach a copy of the evidence of insurability form:

\_\_\_\_\_

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EMPLOYEE'S INSURANCE CLASSIFICATION: \_\_\_\_\_

EMPLOYEE'S SALARY (IF BENEFITS BASED ON SALARY): \_\_\_\_\_

DATE OF LAST SALARY INCREASE: \_\_\_\_\_

DATE OF LAST BENEFIT INCREASE: \_\_\_\_\_

DATE EMPLOYEE LAST WORKED: \_\_\_\_\_

DATE TO WHICH PREMIUMS PAID FOR EMPLOYEE: \_\_\_\_\_

EMPLOYEE LIFE COVERAGE AMOUNTS: \_\_\_\_\_ BASIC LIFE  
\_\_\_\_\_ SUPPLEMENTAL LIFE \_\_\_\_\_ OPTIONAL LIFE

**NOTE: THE POLICY SPECIFIES THOSE COVERAGE AMOUNTS TO WHICH THE WAIVER OF PREMIUM BENEFIT APPLIES IF THE CLAIM IS APPROVED.**

IF THIS CLAIM WAS NOT SUBMITTED WITHIN 12 MONTHS FROM THE DATE THE EMPLOYEE'S DISABILITY BEGAN, PLEASE EXPLAIN (GIVING FULL DETAILS WHY THE CLAIM WAS NOT TIMELY)

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SUBMITTED)

HAS THE EMPLOYEE BEEN TERMINATED FROM EMPLOYMENT?  Yes  No

If "Yes," please explain why \_\_\_\_\_

IS THE EMPLOYEE RECEIVING ANY FORM OF RETIREMENT BENEFITS, INCLUDING DISABILITY RETIREMENT BENEFITS?  Yes  No

If "Yes," please provide full details \_\_\_\_\_

NUMBER OF HOURS PER WEEK THE EMPLOYEE WORKED PRIOR TO CLAIMED DISABILITY:

WAS PERSON CONSIDERED TO BE A:  Full Time Employee  Part Time Employee

REASON EMPLOYEE STOPPED WORKING FOR EMPLOYER \_\_\_\_\_

EMPLOYEE'S JOB TITLE AND DUTIES AS OF DATE LAST WORKED (PLEASE ALSO PROVIDE A COPY OF THE EMPLOYEE'S JOB DESCRIPTION) \_\_\_\_\_

CAN THE EMPLOYEE'S PRESENT JOB BE MODIFIED TO ALLOW THE EMPLOYEE TO CONTINUE TO WORK FOR THE EMPLOYER?  Yes  No

IS THERE ANY TYPE OF ALTERNATIVE WORK AVAILABLE WITH THE EMPLOYER THAT WOULD ACCOMMODATE THE EMPLOYEE'S CLAIMED DISABILITY?  Yes  No

DO YOU EXPECT THE EMPLOYEE WILL EVER BE ABLE TO RETURN TO WORK?  Yes  No

If "Yes," when do you anticipate that he/she will be able to return? \_\_\_\_\_

If "No," why do you anticipate that he/she will be unable to return? \_\_\_\_\_

I hereby certify that the above information is true, accurate and complete. I understand that The Lafayette Life Insurance Company will rely on this information in evaluating a claim for benefits on the employee named above. I further understand that the evaluation of this claim is subject to the terms of the group life insurance policy issued to the policyholder.

DATE: \_\_\_\_\_

Signature of Policyholder's Representative: \_\_\_\_\_

Printed Name of Policyholder's Representative: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number (include area code) \_\_\_\_\_

E-Mail \_\_\_\_\_