

**Waiver of Premium  
Statement of Continuance of Life Insurance  
Protection During Total Disability**

**UnitedHealthcare Specialty Benefits**  
PO Box 7149  
Portland, ME 04112-7149  
1-888-299-2070  
Fax: 1-800-980-0298



Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

UnitedHealthcare Insurance Company  
Unimerica Insurance Company  
Unimerica Life Insurance Company  
Unimerica Life Insurance Company of New York

This statement must be completed by the employee. If the employee is mentally incompetent, the statement should be completed by the committee or guardian, or if none has been appointed, by the beneficiary named in the policy.

1. What is your full name? \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

2. What is your address, city, state, zip? \_\_\_\_\_ Phone #: \_\_\_\_\_  
Cell #: \_\_\_\_\_

3. Give the following facts regarding yourself: Date of Birth \_\_\_\_\_ Sex:  Male  Female  
 Married  Single  Divorced

4. State the causes of your disability. \_\_\_\_\_

5. On what date were you first wholly unable to work due to this sickness or injury? \_\_\_\_\_

6. (a) Are you presently working in any occupation for wage or profit?  Yes  No  Part time  Full time  
If "Yes", please explain \_\_\_\_\_

(b) When do you expect to return to work? Date \_\_\_\_\_

7. Name all physicians who have treated you six (6) months prior to your last day worked. (Use additional sheets if needed)

Name	From	To	Rx?
------	------	----	-----

8. Are you insured under any other policies issued by this Company?  
If so, please give the numbers. \_\_\_\_\_

9. I authorize any insurance company, organization, employer, hospital, physician or surgeon to release any information with respect to this disability review form. I certify that the information I have furnished is true and correct. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

Date \_\_\_\_\_ Signature of claimant \_\_\_\_\_

**To be completed by the employer** Group Number: \_\_\_\_\_ Group Effective Date: \_\_\_\_\_

1. Name of employee \_\_\_\_\_ SSN # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Effective Date \_\_\_\_\_

2. Date of Hire \_\_\_\_\_ Age or date of birth as given at that time \_\_\_\_\_

3. In what occupation was he or she engaged? Include job description. \_\_\_\_\_  Salaried  Hourly  
Hours Worked \_\_\_\_\_ per week  Union  Non-Union  
Salary as of Last Day Worked \$ \_\_\_\_\_

4. On what date was he or she last at work? \_\_\_\_\_  
Benefit Amount \$ \_\_\_\_\_ Basic \$ \_\_\_\_\_ Supp \$ \_\_\_\_\_

5. Why did he or she cease working on that date? \_\_\_\_\_ Work Related?  Yes  No

6. Please include HIPPA Authorization, Beneficiary Election form, Enrollment Card, Training Education & Experience Form.

Tel. No. \_\_\_\_\_ (Include Area Code) Employer \_\_\_\_\_

Address \_\_\_\_\_

Date: \_\_\_\_\_ YR \_\_\_\_\_ By (Signed) \_\_\_\_\_

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

**The Physician's Statement is Requested on the Next Page.**

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT

## Attending Physician's Statement of Disability

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

The patient is responsible for the completion of this form without expense to UnitedHealthcare Insurance Company.

### 1. History

a) When did symptoms first appear or accident happen? Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

b) Date patient was first disabled. Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

c) Has patient ever had same or similar condition?  Yes  No

If "Yes" state when and describe

### 2. Present Condition

Height \_\_\_\_\_ Weight \_\_\_\_\_

a) Subjective symptoms

b) Objective findings

Include results of current x-rays, E.K.G.'s or any other special tests.

c) Is patient \_\_\_\_\_  Ambulatory?  Bed confined?  House confined?  Hospital confined?

### 3. Diagnosis - Primary:

Secondary:

### 4. Treatment

Treatment Plan: \_\_\_\_\_

(a) Date of first visit: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

(b) Date of last visit: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

(c) Date of next visit: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

Frequency of visits \_\_\_\_\_

(d) When did you last examine patient?: Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_  Weekly  Monthly

### 5. Progress

Recovered

Improved

Unimproved

Retrogressed

### 6. Extent of Disability

For Any Occupation

For Employee's Regular Occupation

(a) Is patient now totally disabled?

Yes

No

Yes

No

(b) If no, when was patient able to go to work?

Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

(c) If yes, when do you think patient will be able to resume work

Approximate Date \_\_\_\_\_

Indefinite \_\_\_\_\_

Never \_\_\_\_\_

Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

Mo \_\_\_\_\_ Day \_\_\_\_\_ Yr \_\_\_\_\_

(d) If yes, is patient a suitable candidate for a rehabilitation program?

Yes

No

### 7. Mental Condition

Is the patient competent to endorse checks and direct the use of their proceeds?  Yes  No

### Remarks:

Date \_\_\_\_\_ Signature (Attending Physician) \_\_\_\_\_ Degree \_\_\_\_\_ Telephone \_\_\_\_\_

Street Address \_\_\_\_\_ City or Town \_\_\_\_\_ (or Province) \_\_\_\_\_ Zip Code \_\_\_\_\_

Are you related to the patient by blood or marriage?  Yes  No

**DISCLOSURE AUTHORIZATION**

**TO BE COMPLETED BY EMPLOYEE**

Participant's Name (Please Print): \_\_\_\_\_

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give Unimerica Insurance Company, Unimerica Life Insurance Company of New York, Unimerica Life Insurance Company, UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or  
Claimant's Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship, if other than Claimant: \_\_\_\_\_

**RETURN TO:**  
UnitedHealthcare Specialty Benefits  
PO Box 7149 Portland ME 04112-7466  
Tel 888 299 2070 Fax 800 980 0298