www.dearbornnational.com

Dearborn National®

Strength. Independence. Solutions.

WELCOME TO DEARBORN NATIONAL®

UNDERWRITTEN BY DEARBORN NATIONAL® LIFE INSURANCE COMPANY

Guide to Claims

TABLE OF CONTENTS: GUIDE TO CLAIMS

This guide is designed to assist you in the administration of your group insurance plan.

By providing accurate information and updating changes to the records that you provide to Dearborn National, we will establish a successful partnership in the administration of your plan.

A key identifier for all documents you send to Dearborn National is the group and account number. Please include these numbers on all communications.

We recommend that all persons involved in the administration of your group insurance plan familiarize themselves with all administrative procedures and forms. To understand the rights and obligations of all parties, refer to your group master policy.

GETTING FORMS AND SUBMITTING A CLAIM

WEB SITE

On our Web site, www.dearbornnational.com, you can obtain forms by clicking the "Forms" tab on our Home page and select Group Benefits. Follow the on-screen instructions.

Please complete the appropriate claim form for the type of claim being submitted. There are specific claim forms to be used when submitting Death/Accidental Death, Dismemberment, Accelerated Death Benefit, STD and LTD claims.

Most claim forms contain sections to be completed by the employer, the employee and the attending or treating physician. Note: All sections must be completed in their entirety, and appropriate signatures from the employer, employee and attending physician must be provided in order for the claim to be considered a complete claim submission.

Completed forms and any additional documentation should be mailed or faxed to the address or fax number shown on the claim form.

Questions regarding procedures or proper use of forms and claim status should be directed to the Dearborn National Claim Customer Service department at 1-800-778-2281.
When competing any of the claim forms, please follow the instructions carefully.

FILING A CLAIM

DEATH CLAIM

A death claim form must be completed and submitted to Dearborn National. The following documents must accompany the claim form:

1. A certified copy of the death certificate and
2. The insured's original beneficiary designation form, as well as any changes made subsequently.

See sample on page 4 as a guide to completing this form. (Note: Only sections of the actual form are displayed here.)

DEARBORN NATIONAL® FREEDOM ACCOUNT

The Dearborn National® Freedom Account is an account available on all Group Life, Accidental Dismemberment and Accelerated Death Claims with life insurance payments of $10,000 or more. Life insurance proceeds will be placed into a safe and secure interest-bearing checking account upon approval of the claim. Checks can be written as needed (subject to a $250 minimum per check) to pay expenses. Amounts remaining in the account earn interest at competitive rates.

DEATH CLAIM FORM

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 778-2281
Fax: (312) 540-4706

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

Claimant Name	SSN	Group #	Claimant Phone #

Part 1 – To be completed by Employer/Administrator

Statement of Employer

Employer/Plan Information

Group Name All Model Testing Subsidiary Name _____

Group Number F123456-0001 Account #/Division# _____

Is this insurance part of an ERISA plan? ❑ Yes ☑ No Is the group a labor union? ❑ Yes ☑ No

Address: 11223 Main Street (Street) Main Town (City) IL 60441 (State/Zip)

Name and Title of Authorized Representative Robert Johnson

Phone Number 630-999-1234 Fax Number 630-999-1235

E-Mail Address allmodeltesting@net.com

Preferred communication: ☑ email ❑ phone ❑ fax

Deceased Person Information

Name John Smith Relation to Employee/Member Self
(include Death Certificate)

Insured Information

Name John Smith Social Security No. 333-22-1111

Class _____ DOB: 05-01-1960 Hire Date _____ Occupation _____

Insurance Effective Date or Credits accumulated _____ Date of last premium Contribution _____

Annual Salary _____ Date of Last Salary Increase _____ Work Schedule _____hrs/wk
(If salary based benefit or if any portion of premium is contributory please submit proof of payroll deduction)

Last Day Worked 07-05-2011 Reason for stopping work: death (resignation,

disability, retirement, illness, layoff, leave of absence, vacation, other) _____

If retired, date of retirement _____ If terminated, date of termination _____

If Disabled, provide date of disability _____ Waiver of Premium ❑ Yes ❑ No
Continuation of Life Insurance ❑ Yes ❑ No Extended Life? ❑ Yes ❑ No

Beneficiary/Informant (include address and phone #): _____

Online beneficiary tracking? ❑ Yes ❑ No Tracking System _____

Coverages

Amount of Insurance:
- Basic Life _____
- Supplemental Life _____
- AD&D _____
- Voluntary Life _____
- Dependent Life _____

Additional Benefits:
- Seat Belt _____
- Air Bag _____
- Critical Illness _____
- Education _____
- Other _____

If deceased is a dependent child, please complete the following:

Dependent child's date of birth: _____
Is he/she a full-time student? ☑ Yes ❑ No Name of School _____
Is he/she incapacitated and reliant on the employee for financial support? ❑ Yes ❑ No

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative _____

Print Name Robert Johnson Date 07-21-2011

DEATH CLAIM FORM

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 778-2281
Fax: (312) 540-4706

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

Claimant Name	SSN	Group #	Claimant Phone #

MEMBER/EMPLOYEE:_____ SSN#_____

Part 2 – To be completed by Beneficiary
***If there is more than one beneficiary, each must complete a separate form. See Instruction page If beneficiary is a minor.**

Name Smith (Last) Mary (First) _____ (Middle)

Date of Birth 02-05-1955 Social Security No. 123-45-6789

Address 1223 Easy Way (Street) Main Town (City) IL (State) 60441 (Zip)
(PO Box not acceptable for benefits provided through a Dearborn National Freedom Account.)

Phone 630-555-1234 E-mail marysmith1@hotmail.com

Relationship to deceased spouse Comments:_____

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary _____

Print Name Mary Smith Date 07-21-2011

IRS Certification
Are you a U.S. Citizen: ❑ Yes ❑ No (If No – IRS Form W-8 required) Provide other work ID if available:_____

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. If you fail to certify, we may be required to withhold federal and state tax.

Your Signature _____ Date _____

Printed Name _____

SHORT-TERM DISABILITY (STD) CLAIM

Forms should be completed by submitting a STD claim after the employee's last day worked. Completed forms should be faxed or mailed to Dearborn National at the address shown on the claim form.

Please Note: If you have Voluntary STD coverage with Dearborn National, please submit the most current enrollment form your employee has completed, as well as any recent change forms that have been completed during past annual enrollment periods.

See sample on page 7 as a guide to completing this form. (Note: Only sections of the actual form are displayed here.)

LONG-TERM DISABILITY (LTD) CLAIM

If your company has an STD plan with Dearborn National and the STD claim form has already been completed and submitted to Dearborn National, the claimant may not be required to submit a LTD claim form. Dearborn National will contact the claimant if additional information is required.

If your company does not have an STD plan with Dearborn National, the LTD claim form should be submitted approximately 6 to 8 weeks prior to the end of the elimination period. Completed claim forms should be faxed or mailed to Dearborn National at the address shown on the claim form.

See sample on page 9 as a guide to completing this form. (Note: Only sections of the actual form are displayed here.)

STD CLAIM FORM

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Claim Form

Phone Number: (800) 778-2281
Fax: (312) 540-4706

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

GROUP NUMBER F123456-0001

PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED

- ☑ SHORT-TERM DISABILITY
- ☐ VOLUNTARY STD
- ☐ SPECIFIC DISEASE BENEFIT

CLAIMANT'S STATEMENT (Please Print)

Claimant's Name	Social Security #	Height	Weight	Birth Date
Mark Taylor	444-56-6666	6'1"	195	09/24/1965

Address: Number 4444 Street First Street City Hometown State IL Zip 60690

Phone Number: A/C (630) 661-7777

E-mail mtaylor@net.com

Name of employer	Occupation	Maiden Name	Alias Name
All Model Testing	Accountant		

Are you filing a claim for this disability under the Workers' Compensation Act? ☐ Yes ☐ No

Are you filing a claim for this disability under the Social Security Act? ☐ Yes ☐ No

Describe other income you are receiving:

YES	NO	TYPE *	AMOUNT	DATE BENEFITS BEGAN	DATE BENEFITS TERMINATED	NAME OF INSURANCE CARRIER
☐	☑	Social Security (disability or retirement)	$			
☐	☑	State disability	$			
☐	☑	Retirement (normal, early or disability)	$			
☐	☑	Workers' Compensation	$			
☐	☑	Group disability benefits	$			
☐	☑	Other (describe)	$			

**Please send a copy of your award letter, if applicable.*

1. Date of accident or beginning of sickness: 08/17/2012 Date last worked: 08/16/2010
2. Nature of injury or illness: Broken Leg
3. If injury, describe how, when and where accident occurred:
4. Have you ever had same or similar illness? ☐ Yes ☐ No If yes, give dates: From To
5. Name of hospital(s): Union Hospital Dates confined: From 08/17/2012 To 08/18/2012
   Address of hospital(s): 5555 Main Street
6. Name and address of Doctor(s): Dr. Melissa Harper, 5555 Main Street, Maintown, IL 60610
   Dates of treatment: 08/17/2012 to current
7. Between what dates were you unable to perform any duties? From 08/18/2012 To 10/01/2012 From To

AGREEMENTS AND AUTHORIZATION: I authorize my employer to disclose all information necessary to process my claim to Dearborn National Life Insurance Company (Dearborn National).
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's claim department or its authorized representative(s) information about my medical history or treatment and/or to 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, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize Dearborn National 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 receive notice of Dearborn National'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 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 duplicate 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.
If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, Dearborn National has the right to deny my claim.
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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not enforceable in Oregon or Virginia.)

Signature of Employee Date

STD CLAIM FORM

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 778-2281
Fax: (312) 540-4706

Claim Form

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

Employers Statement (**italicized items should only be completed if the claim is for Waiver of Premium)

Employee's Name	Social Security #	Date of Hire	Effective date of Employee's insurance
Mark Taylor	444-55-6666	06/28/2008	08/01/2008

Employer's Name	Employer's Group Number
All Model Testing	F123456-0001

Employer's Address: 11223 Main Street, Maintown IL 60690

Employer's E-mail Address: allmodeltesting@net.com

Last Day Worked	Date returned	Base salary	Class	Hours worked per week
☑ FT ☐ PT	☐ FT ☐ PT	$ 6000.00 ☐ Hourly ☐ Weekly ☑ Monthly	1	40.00

Worker's Comp Claim filed for this Disability? ☐ Yes ☑ No

SELF ADMINISTERED ONLY: Amount of weekly disability benefit: $_____

Claimant received: Salary continuation through 08/25/2012

Vacation through _____ Sick Pay through _____

Employee's Occupation: Accountant

Premium contribution % by Employer 100 Employee _____ Employee premiums for this coverage pre-taxed? ☐ Yes ☐ No

**Amount of Life Insurance in force:	**Through what date were premiums paid:	**Normal retirement age:
25000.00	09/01/2010	65

Signature	Title	Date	Telephone
	Human Resource Manager	09/02/2012	(630) 555-8888

ATTENDING PHYSICIAN'S STATEMENT

(Must be completed in full at the patient's expense)

Patient's Name: Mark Taylor ☑ Male ☐ Female | Date of Birth: 09/24/1965 | Age: 45

Street Address: 4444 First Street City: Hometown State: IL Zip: 60690

1. Nature and origin of ☐ sickness ☑ injury Diagnosis (describe complications, if any): Fracture of left leg
2. Date symptoms first appeared or date of accident: 08/17/2012 Date patient first consulted you for this condition: 08/17/2012
3. Is this condition work related? ☐ Yes ☑ No
4. Describe any other disease or complications effecting present condition:
5. Date and surgical procedure(s), if any: 08/18/2012
6. If maternity give estimated or actual date of delivery: ☐ Vaginal ☐ C-section
7. Please give dates of treatment other than surgical:
8. Please give hospital name & address with dates of confinement: From 08/17/2012 To 08/18/2012 ☐ Inpatient ☑ Outpatient
   Hospital Name: Union Hospital Address: 5555 Main Street
9. Has patient ever had same or similar condition? ☐ Yes ☐ No (If yes, state when and describe)
10. Is patient still under your care? ☑ Yes ☐ No (If discharged give date and degree of recovery) 10/01/2012
11. Is the patient under the care of another physician? ☐ Yes ☑ No (If yes, provide name, address and phone # of physician)
12. Patient was or will be continuously disabled (unable to work)
    In his/her own occupation From 08/18/2012 Through 10/01/2012 In any other occupation From _____ Through _____
    Patient can return to work ☑ Full time ☐ Part time on 10/01/2012 ☐ Restrictions (specify)
13. Patient was or will be partially disabled? No From _____ Through _____
14. In your opinion, is patient a candidate for rehabilitation? ☑ Yes ☑ To return to own occupation ☐ For another occupation ☐ No
15. If patient is diagnosed as terminal, is life expectancy: ☐ 6 months or less ☑ 12 months or less ☐ Other

Remarks:

Physician's Name: Melissa Harper Office # (630) 555-7777 Fax # (630) 555-8888

Physician's Signature: Date: 08/30/2010

Address: 5555 Main Street City: Maintown State: IL Zip: 60610

Specialty: FP ☐ IM ☐ PM&R ☐ Neuro ☐ Ortho ☑ OBG ☐ Psych ☐ Other

Dearborn National®
Underwritten by Dearborn National® Life Insurance Company

Employer's Report Of Claim

To be Completed by Employer

CLAIMANT

1. Employee's Name (Last, First, Middle Init.)	2. Social Security No.	3. Date of Birth
Johnson, Susan, A.	999-88-7711	08/15/1961

4. Address	City	State	Zip Code
2000 Union Avenue	Austin	TX	78704

EMPLOYMENT

5. Insurance Class	6. Employee Date of Hire	7. Date employee became Insured for LTD	8. Date employee was actually last present at work
All Full Time employees	07/01/2009	07/01/2009	05/29/2010

9. Occupation at time last worked (attach job description): Customer Service Rep

10. Work schedule at time last worked: No. of days per week 5; No. of hours per day 8

11. Reason for stopping:
☑ Sickness ☐ Granted LOA ☐ Laid Off
☐ Retired ☐ Dismissed ☐ Other
☐ Resigned ☐ Vacation

12. Has employee returned to work? ☐ Yes ☑ No
If Yes: ☐ Part-time ☐ Full-time
Date_____ Date_____

INCOME

13. How is employee paid?
☑ Straight Salary ☐ Hourly
☐ Salary & Commissions
☐ Commissions Only ☐ Salary & Bonus

14. Employee's Basic Monthly Earnings
$ 7500.00 LTD Benefit 5000.00
(If salary is based on less than 12 mos. – No. of mos. _____)

15. % of LTD premium contribution: By Employer 100 By Employee _____
Employee premiums for this coverage pre-taxed? ☑ Yes ☐ No

OTHER BENEFITS

16. Has insured received other disability payments since time last worked?

Salary Continuance:	Insured Short Term Disability	Other type:
☐ Yes Wkly. Amt. $_____	☐ Yes Wkly. Amt. $750.00	☐ Yes Wkly. Amt. _____
Date benefits cease _____	Date benefits cease 12/30/2010	Date benefits cease _____
☑ No	☐ No	☐ No

17. Did claim result from job activity?
☐ Yes (Explain)
☑ No

18. Has Workers' Compensation claim been filed?
☐ Yes (Enclose copy of 1st report of accident)
☑ No
☐ Pending
☐ Denied (Enclose copy of denial)

19. Workers' Comp. Weekly Amount:
$ _____

RETIREMENT

20. Is employee covered by employer sponsored retirement plan? ☐ Yes ☑ No

21. Does retirement plan contain a disability provision? ☐ Yes ☑ No

22. Is employee or will this employee be eligible for a disability or retirement pension? ☐ Yes ☑ No
If "Yes" type: ☐ Disability ☐ Retirement ☐ Other _____
Monthly Amount $ _____
Commence date of benefits_____
(enclose copy of summary plan description)

NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.

CERTIFICATION

23. Employer's Name (state association and name of policyholder, if other)	24. Telephone No.	25. Group Policy No.
Sample Group	(999)777-5555	GFZ12345/1

26. Address: 88 East Ridge Road, Austin TX 78704

27. Employer (Taxpayer) I.D. Number (EIN) 37444 - 5333
OR
28. Public Employer Social Security No. 69 _____ - _____

29. Name of person completing this form (please type or print): Sharon Jones

30. Signature of Authorized Insurance Representative | Title | Date

LTD CLAIM FORM

Dearborn National®
Underwritten by Dearborn National® Life Insurance Company

Employee's Claim Statement

To be Completed by Employer

CLAIMANT

1. Full Name (Last, First, Middle Init.)	2. Maiden Name	3. Alias Name	4. Social Security No.	5. Phone Number
Johnson, Susan A	Smith		999-88-7711	(999) 777-5555

6. Address: 2000 Union Avenue City: Austin State: TX Zip Code: 78704

7. Date of Birth	8. Height	9. Weight	10. Sex	11. Marital Status	12. Spouse's date of birth	13. Is spouse employed?
08 15 1961 (Mo. Day Year)	5 ft. 7 in.	155 lbs.	☐ M ☑ F	☐ Single ☑ Married ☐ Widowed ☐ Divorced	25 Mo. 25 Day 1960 Year; First Name: James	☑ Yes ☐ No

14. Number of children (Under age 19)

15. List names and dates of birth of unmarried children who have not finished high school.

EMPLOYMENT

16. Employer's Name: Sample Group

17. Group Policy No: GFZ12345/1

18. Occupation (List the duties of your occupation at the time of disability)
Service customers by phone

19. Date of accident or date first noticed symptoms of illness	20. I have been unable to work because of the disability since:	21. I returned to work on a part time basis on:	22. I returned to work on a full time basis on:
05 30 2010 (Mo. Day Year)	05 30 2010 (Mo. Day Year)	Mo. Day Year	Mo. Day Year

23. Is your accident or illness related to your occupation? ☐ Yes ☑ No

24. If "yes," explain

Have you or do you intend to file a Workers' Comp. Claim? ☐ Yes ☐ No

CLAIM HISTORY

25. Describe how and where accident occurred or describe the onset and nature of your illness.
Lung Cancer

26. Date you were first treated for your illness or injury.
05 30 2010 (Mo. Day Year)

27. Treated by:

	Name	Street Address	City	State	Zip Code
Hospital:	Memorial Hospital	5300 Main Street	Austin	TX	78704
Doctor:	Dr. Robert Taylor	5300 Main Street	Austin	TX	78704

28. Have you ever had the same or similar condition in the past? ☐ Yes ☑ No
If yes complete No. 29.

29. Treated by:

	Name	Street Address	City	State	Zip Code
Hospital:					
Doctor:					

OTHER INCOME

30. Describe other income you are receiving:

Yes	No	Type	Amount	Date Began	Term.
☐	☐	Social Security (disability or retirement)	$		
☐	☐	State disability	$		
☐	☐	Retirement (normal, early or disability)	$		
☐	☐	Workers' Compensation	$		
☐	☐	Group disability benefits	$		
☐	☐	Other (describe) _____	$		

31. Have you applied, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type: Social Security — Date application filed: 09/12/2010

Type: _____ — Date application filed: _____

32. If your request for benefits is approved, do you want us to withhold amounts from each benefit for Federal Income Tax purposes? ☑ Yes ☐ No If yes, please complete and attach IRS Form W4S.

AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Dearborn National® Life Insurance Company's (Dearborn National) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to 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, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim.
This authorization expires on the date I receive notice of Dearborn National's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation. Information provided pursuant to this authorization may be redisclosed by the recipient and no lonnger subject to the protections of the HIPAA Privacy Rule. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from Dearborn National. **If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization,** Dearborn National **has the right to deny my claim.**

Signature of Employee _____ Date _____

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Attending Physicians Statement

Name of patient	Date of Birth	* Please submit bill for records with this claim.
Susan A. Johnson	08/15/1961	

HISTORY

(a) When did symptoms first appear or accident happen?	(b) Date patient ceased work because of disability?	(c) Has patient ever had same or similar condition?
03/15/2010	05/30/2010	☐ Yes If "Yes" state when and describe ☑ No

(d) Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☑ No ☐ Unknown

(e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (Including complications) Please submit all office notes in regard to this condition*
Lung Cancer - Stage 3

(b) Subjective symptoms
Fatigue

(c) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings?)
Cat Scan

TREATMENT

(a) Date of first visit	(b) Date of last visit	(c) Frequency
05/30/2010	08/25/2010	☐ Weekly ☑ Monthly ☐ Other (Specify)

(d) Nature of treatment (Including surgery and medications prescribed, if any)
Removal of mass followed by chemotherapy and radiation therapy

PROGRESS

(a) Has patient ☐ Recovered? ☐ Improved? ☑ Unchanged? ☐ Retrogressed?

(b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No Confined from 05/30/2010 through 06/12/2010
If, yes, give Name and Address of Hospital: Union Hospital

CARDIAC

(a) Functional capacity (American Heart Ass'n.)
☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
☑ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood Pressure (last visit) 145/90 systolic/diastolic

IMPAIRMENT

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles).
☐ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
☐ Class 2 - Medium 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 minimum (sedentary*) activity. (75-100%)
Remarks:

(b) Mental Impairments (If applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?
☐ 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, physiological, personal and social adjustment (severe limitations)
Remarks:

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ☑ Yes ☐ No ANY OTHER WORK ☑ Yes ☐ No

(b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future? 05/30/2010
☐ 1 Mo. ☐ 1-3 Mo. ☑ 3-6 Mos. ☐ Never. Applies To: ☐ Patient's job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☑ Yes ☐ No ANY OTHER WORK ☑ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☑ No

(c) When could trial employment commence? Date 3 - 6 months (PATIENT'S JOB) ☐ Full-time ☑ Part-time Date 3 - 6 moths (ANY OTHER WORK) ☐ Full-time ☑ Part-time

REMARKS

(Limitations, Therapy, etc.)

Name (Attending Physician) *Print*	Degree	Telephone / Fax
Melissa Harper	M.D.	Telephone (666)555-4444 Fax #: (666)555-4443

Street Address	City or Town	State	Zip Code
1111 First St	Austin	TX	78704

Signature	Date

TAX REPORTING GUIDELINES

Internal Revenue Service (IRS) Publication 15-A requires Dearborn National to report to employers the benefits paid and taxes withheld for their employees.

As a policyholder, you are responsible for matching the employee's portion of social security and medicare taxes (FICA) on all taxable STD and LTD benefits as well as associated W-2 reporting. Paid claims reports will be sent weekly, quarterly and annually.

TAXABILITY OF DISABILITY BENEFITS

STD and LTD benefits may be considered taxable income. The taxability of these benefits is determined by who pays the premium and how premium is paid.

If the employee pays any portion of the premium on a post-tax basis, the portion of their benefit attributable to their percentage of premium contribution is not taxable. If any portion of the premium is paid by the employee on a pre-tax basis, the portion of their benefit attributable to their percentage of premium contribution is taxable. Any portion of their benefit attributable to their employer's contribution is taxable.

If the benefit is taxable, Dearborn National is required to withhold social security and medicare taxes (FICA); however, federal income tax (FIT) is not required to be withheld. Dearborn National will withhold FIT by request.

IRS Form W4-S should be submitted with the claim form to Dearborn National if FIT withholding is requested by your employee.

YEAR-END TAX REPORTING

For those employers whose group insurance plan includes STD or LTD insurance, Dearborn National can also prepare and issue a W-2 for each insured receiving disability payments. Groups must be fully insured. A signed W-2 agreement is required. Please refer to the agreement (found on our website) for specific time limits that must be met.

Paid Disability Claims
FICA/FIT Withholding Report for: 1/1/2008-3/31/2008

Policyholder: **SAMPLE GROUP** Policy #: **GFZ00001/1**
Division #: **1** Dept: **1**

SAMPLE GROUP

Claim #	LOB	Check #	Benefit Period	Pay Type	Pay Date	Payee	Pmt Amt	SS	Med	Fed	State	Other	Check Amt
Claimant:	SUSAN JOHNSON					SSN:	111223333						
200825999	REGULAR LTD	10437576 8	12/08/07 -01/08/08	CHECK	1/22/08	SUSAN JOHNSON	1265.72	78.47	18.35	0.00	0.00	0.00	1168.90
200825999	REGULAR LTD	10443947 9	01/05/08 -02/02/08	CHECK	2/11/08	SUSAN JOHNSON	1363.08	84.51	23.72	0.00	0.00	0.00	1254.85
200825999	REGULAR LTD	1045315710	02/02/08 -03/01/08	CHECK	3/6/08	SUSAN JOHNSON	1363.08	84.51	19.76	200.00	0.00	0.00	1058.81
						Certificate Holder Totals:	3991.88	247.49	61.83	200.00	0.00	0.00	3482.56
Claimant:	DANIEL SMITH					SSN:	222334444						
200825998	REGULAR STD	10434107 4	12/03/07 -12/24/07	CHECK	1/11/08	DANIEL SMITH	1269.39	78.70	18.41	0.00	0.00	0.00	1172.28
						Certificate Holder Totals:	1269.39	78.70	18.41	0.00	0.00	0.00	1172.28
Claimant:	AMY WRIGHT					SSN:	333445555						
200825997	REGULAR STD	10441657 3	12/12/07 -02/06/08	CHECK	2/1/08	AMY WRIGHT	2928.00	181.54	42.46	0.00	0.00	0.00	2704.00
200825997	REGULAR STD	10446195 4	02/06/08 -02/20/08	CHECK	2/15/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
200825997	REGULAR STD	10451693 5	02/20/08 -03/05/08	CHECK	3/3/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
200825997	REGULAR STD	10455658 6	03/05/08 -03/19/08	CHECK	3/14/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
200825997	REGULAR STD	10461433 7	03/19/08 -04/02/08	CHECK	3/31/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
						Certificate Holder Totals:	5856.00	363.06	84.90	0.00	0.00	0.00	5408.04
						Group Totals:	11,117.27	689.25	165.14	200.00	0.00	0.00	10,062.88