LONG TERM DISABILITY CLAIM FORM EMPLOYEE STATEMENT

MetLife
Expatriate Benefits
600 King Street
Wilmington, DE 19801 USA
Toll Free (Within US): 1-800-451-1847
Direct: +1-302-661-8674
Fax: +1-302-427-0817
Email: wilmclaims.metlifeexpat@alico.com
www.metlifeexpat.com

Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the claim form.
4. Fax this form to expedite your claim – retain original for your records.
5. *Contact MetLife Expatriate Benefits at +1-302-661-8674 for any questions you have on completing this form.

Section 1: Personal Information

Name (Last, First, MI) – MUST ANSWER	**Employer** – MUST ANSWER	**Group Report #**	**ID Number**

Address / City / State / Zip Code	Date of Birth (MM/DD/YY)	Sex	**Social Security #** MUST ANSWER
	mm/dd/yy	☐ M ☐ F	

Home Phone #	Work Phone #	Occupation	Marital Status	Tax Exemptions
			☐ Married ☐ Single ☐ Other	

Dependent Information:

	Name	Date of Birth	SS#
Spouse		mm/dd/yy	
Children		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	

Section 2: Claim Information

Is your disability due to ☐ Injury/Accident? ☐ Illness?

Is this condition work related? ☐ Yes ☐ No

If due to injury/accident, give date, time and details. (When, Where, How)

Date of first treatment for this condition	**Date Last Worked** MUST ANSWER	Date Disability Began	Height	Weight
mm/dd/yy	mm/dd/yy	mm/dd/yy		

Name, address, phone number of your primary attending physician.

Name of physicians/providers who have treated you within the past 2 years.

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason for Visit
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	

~~Has~~ the patient been hospitalized? ☐ ~~Y~~es ☐ No If Yes, give dates ~~s~~from mm/dd/yy to mm/dd/yy ☐ Inpatient ☐ Outpatient
Name and address of hospital

Circle Highest Education Level Completed.	Degrees, Certificates, License/Skills or training obtained
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	

Please describe what prevents you from performing the duties of your job.

Have you applied for or are you receiving income from any other sources? ☐ Yes ☐ No
If yes, provide the following information.

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	☐	☐			mm/dd/yy mm/dd/yy
Short Term Disability	☐	☐			mm/dd/yy mm/dd/yy
Worker's Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Social Security	☐	☐			mm/dd/yy mm/dd/yy
Dependent Social Security	☐	☐			mm/dd/yy mm/dd/yy
No Fault (Income Replacement)	☐	☐			mm/dd/yy mm/dd/yy
Retirement/Pension	☐	☐			mm/dd/yy mm/dd/yy
Permanent Total Disability	☐	☐			mm/dd/yy mm/dd/yy
Other (Please Identify)	☐	☐			mm/dd/yy mm/dd/yy

Name: (Last, First, Middle Initial)	Social Security #	Report #	Claim #

Agreement To Reimburse Overpayment of Long Term Disability Benefits

I, _____ acknowledge that, if my disability claim is or has been approved, under my Long Term Disability coverage, Metropolitan Life Insurance Company (MetLife) is authorized to reduce the benefits otherwise payable to me by certain amounts paid or payable to me under disability or retirement provisions of the Social Security Act (including any payments for my eligible dependents), under a Worker's Compensation or any Occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

I understand that, if my disability claim is or has been approved, MetLife is willing to make advance monthly disability payments to me, which because of amounts paid or payable under the laws described above may be in excess of the benefits actually due to me. However, I also understand and accept that MetLife will make these payments, only if I make certain statements which I represent and warrant to be true and only if I agree as follows:

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefit payment or a compromise settlement.

2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my Plan of Benefits after I have received my first monthly benefit check from MetLife. As proof of this, I agree to send to MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application.

3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my claim for benefits as specified in my Plan of Benefits.

4. As specified in my Plan of Benefits, when I, my spouse or my dependents receive any disability or retirement payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award, notification or check to MetLife.

5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, as specified in my Plan of Benefits, I agree to repay to MetLife any and all such amounts which MetLife or employer has advanced to me in reliance upon this Agreement.

6. If for any reason MetLife or employer is not repaid, then I understand that MetLife may reduce my monthly benefit below the minimum monthly benefit amount as stated in my Plan of Benefits, until the overpayment is reimbursed in full.

7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

I understand that when MetLife issues an advance, it is relying on my statements and agreements herein. My acceptance of an advance, along with my signature below, is my acceptance of terms of this Agreement.

_____	mm/dd/yy	_____	mm/dd/yy
Witness Signature	**Date**	**Claimant's Signature**	**Date**

Expatriate Benefits
600 King Street
Wilmington, DE 19801 USA

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Instructions for completing the form:
1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

_____ _____ – _____ – _____

Name of Employee (Please Print) **Social Security Number**

Claim Number: _____

Authorization to Disclose Information About Me

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its disability benefit plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and disability claim.
2. **I permit:** MetLife to disclose to my employer in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

I understand that I may revoke this authorization at anytime by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40511-4590, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

_____ mm/dd/yy

Signature of Employee **Date**

Disability Claim Employee Statement (Continued)

Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material there to may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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 loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, Rhode Island, West Virginia – 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.

California – For your protection California law requires the following to appear of 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 life 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 respect to a settlement or award from insurance proceeds, shall be reported to the Colorado divisions of insurance within the department of regulatory agencies to the extent required by applicable law.

Delaware – Any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim 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.

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 guilty of a felony of the third degree.

Hawaii – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho – Any person who knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – Any person who knowingly and with the 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 there to commits a fraudulent insurance act, which is a crime.

Maine – 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 files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – A person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Disability Claim Employee Statement (Continued)

Fraud Warning (continued) :

New Jersey – Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

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 civil fines and criminal 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 stated value of the claim for each such violation.

Ohio – A person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly and with the 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.

Oregon – A person who knowingly and with intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia, Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas – 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.

Name of Employee (Please Print):_____ Social Security Number:_____

Signature of Employee:_____ Date:____ mm/dd/yy

Claim #: _____

ATTENDING PHYSICIAN STATEMENT

MetLife®

Expatriate Benefits
600 King Street
Wilmington, DE 19801 USA

Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
2. Sign the claim form.
3. Fax this claim form to expedite your claim – retain original for your records.

The following section must be completed and signed by the employee/patient. Any fee for the completion of this form is the patient's responsibility.		Occupation	
Name- **MUST ANSWER**	Social Security# **MUST ANSWER**	Employer- **MUST ANSWER**	Group Report #

I hereby authorize my physician to release any information acquired in the course of examination or treatment.

Signature of Employee _____ Date mm/dd/yy

Date of Birth mm/dd/yy

The following section must be completed and signed by the attending physician.

The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form. A MetLife claim representative may telephone your office if additional information is needed.

History

Symptoms result from: ❍ Injury ❍ Illness

Is condition work-related? ❍ Yes ❍ No

Initial date of treatment mm/dd/yy

Most recent date of treatment mm/dd/yy

Did you advise the patient to cease the above noted occupation? ❍ Yes ❍ No If Yes, Date mm/dd/yy

Names and Phone Numbers of the providers the patient was referred to:

Name	Phone #	Name	Phone #

Has patient been hospitalized? ❍ Yes ❍ No If Yes, Day Confined mm/dd/yy Through mm/dd/yy

Name and address of facility

Diagnosis and Treatment

Primary Diagnosis Code ____ - ____ Diagnosis _____

Secondary Diagnosis Code ____ - ____ Diagnosis _____

Subjective Symptoms _____

Objective Findings (Include copies/results of any x-rays, lab tests', EKG's, MRI's, scans and office notes)

Current and Recommended Treatment Plans _____

If surgery performed/anticipated, provide the following:

CPT-4 _____ _____ mm/dd/yy

Procedure Date

Medications prescribed (names, dosages)

_____ _____

_____ _____

_____ _____

Name of Employee: _____ **Social Security Number:** _____

Psychological Functions

Check applicable box below

- ☐ 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 some 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 and engage in interpersonal relations (marked limitations)
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

What stress factors or problems with interpersonal skills have affected patient's ability to perform, the duties of his or her job?

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

Physical Capabilities

(a) Patient's ability to: (circle)

	Hours	(check)	
Sit	012345678	☐ Continuously	☐ Intermittently
Stand	012345678	☐ Continuously	☐ Intermittently
Walk	012345678	☐ Continuously	☐ Intermittently

(b) Patient's ability to: (circle)

Climb	Yes	No
Twist/bend/stoop	Yes	No
Reach above shoulder level	Yes	No
Operate a motor vehicle	Yes	No

(c) Patient's ability to lift/carry: (check)

	Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐
Over 100 lbs.	☐	☐	☐	☐

(d) Patient's ability to perform repetitively: (circle)

	Right Hand		Left Hand	
Fine finger movements	Yes	No	Yes	No
Eye/hand movements	Yes	No	Yes	No
Pushing/pulling	Yes	No	Yes	No

Dominant hand R ☐ L ☐

(e) In your opinion, why is patient unable to perform job duties?

(f) Patient can work a total of_____ hours per day?

(g) Do you expect improvement in any area?
(If so please comment and give dates/timeframes.)

Cardiac

Functional Capacity (American Heart Association) Complete only if applicable.

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

Blood Pressure (latest reading) ___ / __ as of (date) _____ mm/dd / __ yyyy

Is patient in a cardiac rehabilitation program?

Prognosis

Have you advised patient to return to work?

☐ Yes If Yes, date of return__ mm/dd/yy

☐ To regular occupation ☐ Full Time ☐ Part Time
☐ To any other occupation ☐ Full Time ☐ Part Time

☐ No If Not, please explain

Any work/activity restrictions applicable (please be specific)

Rehab

Do you suggest that the patient become involved in any of the following? Please check as many as apply.

If so, was this discussed with the patient? ☐ Yes ☐ No

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Cardiac Rehabilitation
- ☐ Pain Management Program
- ☐ Work Hardening Program
- ☐ Job Modification
- ☐ Vocational Rehabilitation
- ☐ Psychological Counseling
- ☐ Other

Disability Claim Attending Physician Statement (Continued)

Name of Employee:_____ Social Security Number:_____

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Disability Claim Attending Physician Statement (Continued)

Name of Employee:_____ Social Security Number:_____

Fraud Warning (continued) :

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Physician

Name _____ Degree/Specialty _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone # _____ Fax # _____ Tax ID # _____

Contact person if additional information is necessary

Signature _____ Date mm/dd/yy

LONG TERM DISABILITY CLAIM FORM EMPLOYER STATEMENT

MetLife

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600 King Street
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Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
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Section 1: Employer Information

Name of Employer - MUST ANSWER	Group Report #	Sub-Division #	Branch #

Address City State ZIP Code	Employer Tax ID#

Subsidiary or Division Name	Address

Contact Person's Name	Phone #

Section 2: Employee Information

Name (Last, First, MI) - MUST ANSWER	**Social Security # - MUST ANSWER**	Date of Birth (MM/DD/YY)	Sex M M M F
		mm/dd/yy	

Address City State ZIP Code	Home Phone #

Marital Status M Married M Single M Other	W4 Filing Status Exemptions:	Date of Hire	Current Occupation	How long at this occupation?
		mm/dd/yy		

Work Location Address	Employee ID #	Work Phone #

Supervisor Name	Phone #

Section 3: Claim Information

Is claim due to M Injury? M Illness?	Description of illness or injury (including date of accident):
Is condition work-related? M Yes M No	

If yes, provide name and address of Workers' Compensation Carrier.

Name _____ Address _____

Contact Person's Name _____ Phone # _____ Worker's Comp. Claim # _____

Date Last Worked MUST ANSWER	First Date of Absence	Date Returned to Work M Actual M Estimated	Eff. Date of Coverage	Earn. On Last Day Worked	Benefit Rate
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy		

Premium Contributions Employer % Employee % M Pre-tax M Post-tax	Basic Earnings (exclusive of overtime, bonus, etc.) $ M Hourly M Weekly M Monthly	Average Hours Worked Per Week

Employee's Status As Of First Day Absent M Active M LOA M Terminated M Vacation M Laid Off M Retired If other than active, Please explain	L D Date Enrollment Card Signed D mm/dd/yy	If buy up: Date Enrollment Card Signed mm/dd/yy

Has employee had previous absences from work due to disability? M Yes M No If yes, provide dates and medical conditions

Can employee's job be modified? M Yes M No If yes, describe how.	Has return to work been discussed with employee? M Yes M No

To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the following sources:

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave ▶	M ▶	M			mm/dd/yy mm/dd/yy
Short Term Disability ▶	M ▶	M			mm/dd/yy mm/dd/yy
Workers' Compensation ▶	M ▶	M			mm/dd/yy mm/dd/yy
State Disability ▶	M ▶	M			mm/dd/yy mm/dd/yy
Social Security ▶	M ▶	M			mm/dd/yy mm/dd/yy
Dependent Social Security ▶	M ▶	M			mm/dd/yy mm/dd/yy
No Fault (Income Replacement) ▶	M ▶	M			mm/dd/yy mm/dd/yy
Retirement/Pension ▶	M ▶	M			mm/dd/yy mm/dd/yy
Permanent Total Disability ▶	M ▶	M			mm/dd/yy mm/dd/yy
Other (Please identify) ▶	M ▶	M			mm/dd/yy mm/dd/yy

Continued on following page

Section 4: Employee's Job Description

Name of Employee: _____ Usual Days Worked _____/per week

Employee's Job Title: _____ **Hours Worked** _____/per week

Social Security Number: _____ **Claim Number** _____

This section should be completed by someone who is familiar with the employee's job functions (e.g. manager or supervisor). Complete all sections. This section must be completed AND you must also attach a copy of your company's job description for the employee.

Name of Person Completing This Section:

_____ Title: _____

Signature: _____ Date: mm/dd/yy

Place an X in each of the appropriate boxes to describe the extent of the specific activity performed by this employee.

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
1. Sitting	☐	☐	☐	☐	☐
2. Standing	☐	☐	☐	☐	☐
3. Walking	☐	☐	☐	☐	☐
4. Bending Over	☐	☐	☐	☐	☐
5. Twisting	☐	☐	☐	☐	☐
6. Climbing	☐	☐	☐	☐	☐
7. Reaching Above Shoulder Level	☐	☐	☐	☐	☐
8. Crouching/Stooping	☐	☐	☐	☐	☐
9. Kneeling	☐	☐	☐	☐	☐
10. Balancing	☐	☐	☐	☐	☐
11. Pushing and Pulling	☐	☐	☐	☐	☐
12. Repetitive Use of Foot Control					
A. Right Foot Only	☐	☐	☐	☐	☐
B. Left Foot Only	☐	☐	☐	☐	☐
C. Both Feet	☐	☐	☐	☐	☐
13. Repetitive Use of Hands					
A. Right Hand Only	☐	☐	☐	☐	☐
B. Left Hand Only	☐	☐	☐	☐	☐
C. Both Hands	☐	☐	☐	☐	☐

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
14. Grasping					
A. Simple/Light					
1. Right Hand Only	☐	☐	☐	☐	☐
2. Left Hand Only	☐	☐	☐	☐	☐
3. Both Hands	☐	☐	☐	☐	☐
B. Firm/Strong					
1. Right Hand Only	☐	☐	☐	☐	☐
2. Left Hand Only	☐	☐	☐	☐	☐
3. Both Hands	☐	☐	☐	☐	☐
15. Fine Finger Dexterity					
A. Right Hand Only	☐	☐	☐	☐	☐
B. Left Hand Only	☐	☐	☐	☐	☐
C. Both Hands	☐	☐	☐	☐	☐
16. Use of Head and Neck in:					
A. Static Position	☐	☐	☐	☐	☐
B. Twisting	☐	☐	☐	☐	☐
C. Looking Up	☐	☐	☐	☐	☐
D. Looking Down	☐	☐	☐	☐	☐

	Never 0% Of Time	Occasionally 1-33% Of Time	Frequently 34-66% Of Time	Continually 67-100% Of Time
17. Lifting or carrying				
A. Up to 10 lbs	☐	☐	☐	☐
B. 11 – 20 lbs	☐	☐	☐	☐
C. 21 – 50 lbs	☐	☐	☐	☐
D. 51 – 100 lbs	☐	☐	☐	☐
E. 100 + lbs	☐	☐	☐	☐
18. Frequency of Interpersonal Relationships Necessary to Perform the Job	☐	☐	☐	☐
19. Frequency of Stressful Situations Necessary to Perform the Job	☐	☐	☐	☐

In the course of performing the job, the employee is required to:

	Yes	No
20. Drive cars, trucks, forklifts and/or other equipment	☐	☐
21. Be around moving equipment and/or machinery	☐	☐
22. Walk on uneven ground	☐	☐
23. Be exposed to dust, gas, or fumes	☐	☐
if yes, are respirators required	☐	☐
24. Be exposed to marked changes in temperature or humidity	☐	☐
25. Is overtime required on a routine basis	☐	☐

Continued on following page

Disability Claim Statement (Continued)

Name of Employee: _____ Social Security Number: _____

Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material there to may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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 loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, Rhode Island, West Virginia – 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.

California – For your protection California law requires the following to appear of 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 life 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 respect to a settlement or award from insurance proceeds, shall be reported to the Colorado divisions of insurance within the department of regulatory agencies to the extent required by applicable law.

Delaware – Any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim 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.

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 guilty of a felony of the third degree.

Hawaii – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho – Any person who knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – Any person who knowingly and with the 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 there to commits a fraudulent insurance act, which is a crime.

Maine – 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 files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – A person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing 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 false or misleading information is subject to criminal and civil penalties.

Fraud Warning (continued) :

Name of Employee: _____ **Social Security Number:** _____

Fraud Warning (continued) :

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 civil fines and criminal 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 stated value of the claim for each such violation.

Ohio – A person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Oklahoma – WARNING: Any person who knowingly and with the 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.

Oregon – A person who knowingly and with intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia, Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas – 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.

Employer's Authorized Representative

Name _____ Title: _____ Phone # _____

Signature _____ Date: mm/dd/yy