Group Disability

Submit to: **Aetna U.S. Healthcare**
Life Insurance Service Center
151 Farmington Avenue
Hartford, CT 06156-7320

- Employee completes Sections 1 - 3.
- Employer completes Section 4.
- Please submit this form along with completed Attending Physician Statement to the above address.

1. Employee Information

Employer Name		Branch
Employee Name	Birthdate *(MM/DD/YYYY)*	Sex ☐ Male ☐ Female
Address (street, city, state, zip code)		Daytime Telephone Number ( )
Occupation	Cause of Disability	

2. Attending Physician Information

List the physician(s) now attending you. (Use back if more space is needed)

Physician's Name	Physician's Address	Condition Treated

3. Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature ___________________________ Date ____________

4. Employer Information

Control Number	Control Suffix	Claim Account	Social Security Number - -
Employee is ☐ Hourly ☐ Salary	Amount of Insurance in Force on Date Last Worked $	Rate of Basic Earnings on Date Last Worked $ ____________ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	

Reason Employee Did Not Return to Work After Last Day Worked	Date Last Worked	Effective Date Insurance Discontinued if Not in Force
Type of Coverage ☐ DBO-AID ☐ Premium Waiver ☐ PTD *(check one)*: ☐ Installment, provide terms ________Months ☐ Lump Sum	Date Employee First Began Work	Date Insurance Took Effect

Was employee required to submit evidence of insurability?
☐ No ☐ Yes, give date submitted ________

Rate of Basic Earnings on Date Last Worked ***(complete only if employee elected Paid-up Coverage)***
$ _____________ Contributions from last renewal date
$ _____________ Contributions for policy year prior to last renewal date

Last Contribution Covered Period Ending ***(complete only if employee contributed part of premium)***

Contributions should cease upon completion of this form if policy is Paid-up Insurance. If contributions are for Term Insurance only, check one of the following: ☐ Term ☐ Permanent

Employer's Address (street, city, state, zip code)	**Telephone Number** ( )
Signature of Employer's Authorized Representative	Date

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 claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties. **Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

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