BEST Life™
BEST Life and Health Insurance Company

Short Term Disability Claim Statement

P.O. Box 3023, Meridian, ID 83680-3023
(800) 433-0088 • (949) 222-1004 fax
www.bestlife.com

EMPLOYER STATEMENT

To be completed by the Employer on behalf of the employee. Please print or type. Attach separate sheet if necessary.

Your Name and Title, Company Name and Address	Phone Number	Email Address	Group Policy No.

Full Name of Claimant	Date of Hire	Effective date of insurance	Class	Customer No.

Occupation, title or position (Attach a job description)	Did disability occur as a result of employment?	Work History
	☐ Yes ☐ No ☐ Currently disputed	Date Last Worked: Hours Worked Per Week:

Work schedule at time of disability	Has claimant returned to work?	Method Claimant is Paid
days/week hrs/day	☐ Yes, Date: ☐ With restrictions ☐ Full Capacity ☐ No	☐ Hourly ☐ Commission only ☐ Salaried ☐ Salary & Bonus ☐ Salary & Commission ☐ Other:

Weekly Earnings (as defined by plan)	Weekly benefit amount	Was claimant covered under a prior disability plan?
$	$	☐ Yes, Effective date of prior plan: Term date of prior plan: ☐ No

Should FICA taxes not be withheld from claimant's benefits?	☐ Yes, please explain: ☐ No

Does claimant contribute towards cost of STD insurance?	Has claimant's contribution changed the past 4 years?	Send check to claimant's home?
☐ Yes, ☐ Pre-Tax ☐ Post-tax: % paid by employer, % paid by claimant ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

CLAIMANT'S STATEMENT

Complete, Sign and Date your portion of the claim form including the Authorization for Release of Information and the Fraud Statement. Have your Physician complete the Attending Physician's Statement. Send all documents to the address listed above.

Name of Employee	Email Address	Home Phone Number

Date of Birth	Social Security Number	Gender	Type of Disability	Date Unable to Work
		☐ Male ☐ Female	☐ Accident ☐ Illness ☐ Pregnancy	

Employee's Address	Physician's Name and Address

Briefly describe how and where accident occurred or list symptoms of illness and diagnosis / prognosis (attach separate sheet if necessary)

Have you returned to work? ☐ Yes, on the date of: , ☐ Part-time ☐ Full-time ☐ No, I will return to work on: ☐ Part-time ☐ Full-time

Check the following sources of income you are receiving or are entitled to receive:

☐ Salary, Wages or Commissions ☐ Retirement or Pension Plan ☐ Social Security Retirement ☐ National Guard/Military Reserves ☐ State Disability
☐ Social Security Disability ☐ Railroad Retirement Act ☐ Worker's Compensation ☐ Other Sources

For each source selected above, please provide the following information:

Source	Amount of Income		Application File Date	Benefit Effective Date
	Amount	Frequency		

Provide documentation of any source selected above (award notices, denial notices, or applications).

Before submitting, make sure all parts of this Claim Statement are completed as instructed. DO NOT SEPARATE the pages.

STDCF-0611

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Attending Physician's Statement

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ATTENDING PHYSICIAN'S STATEMENT

Patient must pay any costs for completion of this form. To be completed by Attending Physician.

Name of Patient	WT	HT	Date of Patient's Disability	For injury, provide date of accident

Date you last treated for this disability	Are you the patient's regular physician?
	☐ Yes ☐ No If no, physician's name and address:

Was patient hospitalized?	Hospital Name and Address
☐ Yes ☐ No If yes, Admission Date: Discharge Date:	

Patient's symptoms result from (Check all that apply)

☐ Employment ☐ Illness ☐ Auto Accident ☐ Other Accident ☐ Pregnancy, Expected/Actual Delivery Date:

Type of Delivery: ☐ Vaginal ☐ Cesarean Section

Date limitations began:	Date limitations end:	Estimated Time of Partial or Total Disability

ICD9-CM Codes	Symptoms	Diagnosis/Prognosis

If applicable, list surgical procedures and provide dates:

FUNCTIONAL LIMITATIONS

Select limitation of functional ability (as defined by the US Department of Labor's Federal Dictionary of Occupational Titles):

☐ Class 1 – No limitation, capable of heavy work – exert 50 to 100 lbs – force frequently

☐ Class 2 – Medium activity – exert occasional 20 to 50 lbs – force and/or 10 to 25 lbs force frequently

☐ Class 3 – Slight limitation, capable of light work – exert occasional 20 lbs force and/or up to 10 lbs force frequently

☐ Class 4 – Moderate limitation, capable of sedentary, clerical or administrative work – occasional 10 lbs force, mostly sitting

☐ Class 5 – Severe limitation, incapable of minimal activity or sedentary work ☐ Bed confined ☐ House confined

Describe patient's capabilities: N=Never O=Occasionally (1/4 – 2-1/2 hours) F=Frequently (2-1/2 – 5-1/2 hours) C=Continuously (5-1/2 – 8 hours)

_____ Standing _____ Sitting _____ Walking _____ Driving _____ Bending _____ Data entry

Lifting: _____ 1-5 lbs _____ 6-10 lbs _____ 11-25 lbs _____ 26-50 lbs _____ 51-100 lbs _____ Over 100 lbs

Carrying: _____ 1-5 lbs _____ 6-10 lbs _____ 11-25 lbs _____ 26-50 lbs _____ 51-100 lbs _____ Over 100 lbs

Date capabilities began	Will patient's functional capabilities increase?	If yes, please provide anticipated date
	☐ Yes ☐ No	

Is patient able to work with job modifications?	Date patient able to work	Remarks and/or treatment plan
☐ Yes ☐ No	☐ Full-time ☐ Part-time	

Name of attending physician (please print) State Physician Number and State of Licensure Telephone Number

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Authorization for Release of Information

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To be completed by the employee filing for benefits.

Claimant's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give BEST Life and Health Insurance Company, BEST Re, BEST Health Plans, Pension Administrators, B.E.S.T., and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- Any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- Any physician or medical practitioner;
- Any hospital, clinic or other health care facility;
- Any insurance or reinsurance company (including, but not limited to, the Recipient or any other BEST Family of Companies which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- Any consumer reporting agency or insurance support organization;
- My employer, group policyholder, or benefit plan administrator; and
- The Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- Determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- Detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the BEST Life and Health Insurance Company Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request: BEST Life and Health Insurance Company, P.O. Box 890, Meridian, ID 83890. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Claimant/Guardian/Representative Date

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Short Term Disability
Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or person files an application for insurance or statement of claimant 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.

The following disclosures are required by state law and are based on the state where you live:

Alaska residents: 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 residents: A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Colorado residents: 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.

District of Columbia or Hawaii residents: 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.

Idaho or Indiana residents: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony.

Louisiana, Maryland or New Mexico residents: 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.

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any provider of medical services or physician who has treated me or other person who has attended or examined me or any company or government agency to furnish to BEST Life and Health Insurance Co, or any of their authorized representatives, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photocopy of this form will be as valid as the original.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Print Claimant's Name | Signature of Claimant, with Title, if any

Signature of Policyholder's Representative ***X*** | Date

Signature of attending physician ***X*** | Date

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.

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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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."

Arkansas: The following statement is required by Arkansas Law
23-66-503(a): 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.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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: COLORADO LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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.

DC: The District of Columbia requires us to notify you of the following:
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: FLORIDA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: Hawaii Law requires us to notify you of the following: For your protection, Hawaii law requires you 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: IDAHO LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly, and with intent to defraud any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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 and 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, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Louisiana and Rhode Island: 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: New Mexico state law requires us to notify you of the
following: 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 guilt of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any 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 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.

Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

Pennsylvania: THE COMMONWEALTH OF PENNSYLVANIA REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.

Tennessee: TENNESSEE STATE LAW REQUIRES US TO NOTIFY YOU OF THE
FOLLOWING: "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: Texas law requires us to notify you of the following: 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.

Virginia: THE COMMONWEALTH OF VIRGINIA REQUIRES US TO NOTIFY YOU OF THE
FOLLOWING: 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.

Washington: THE STATE OF WASHINGTON REQUIRES US TO NOTIFY YOU OF THE
FOLLOWING: "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."

All other states: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.