



BEST Life and Health Insurance Company

P.O Box 19721, Irvine, CA 92623-9721
(800) 433-0088 • (949) 222-1004 fax
www.bestlife.com

Short Term Disability Claim Statement

EMPLOYER STATEMENT

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

Form with fields for: 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; Did disability occur as a result of employment?; Work History; Work schedule at time of disability; Has claimant returned to work?; Method Claimant is Paid; Weekly Earnings; Weekly benefit amount; Was claimant covered under a prior disability plan?; Should FICA taxes not be withheld from claimant's benefits?; Does claimant contribute towards cost of STD insurance?; Has claimant's contribution changed the past 4 years?; Send check to claimant's home?

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.

Form with fields for: Name of Employee; Email Address; Home Phone Number; Date of Birth; Social Security Number; Gender; Type of Disability; Date Unable to Work; Employee's Address; Physician's Name and Address; Briefly describe how and where accident occurred or list symptoms of illness and diagnosis / prognosis; Have you returned to work?; Check the following sources of income you are receiving or are entitled to receive; For each source selected above, please provide the following information; 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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Short Term Disability 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? | | |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No If no, physician's name and address: | | |
| Was patient hospitalized? | | Hospital Name and Address | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Admission Date: Discharge Date: | | | | |
| Patient's symptoms result from (Check all that apply) | | | | |
| <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident <input type="checkbox"/> Pregnancy, Expected/Actual Delivery Date: | | | | |
| Type of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> 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): | | | | |
| <input type="checkbox"/> Class 1 – No limitation, capable of heavy work – exert 50 to 100 lbs – force frequently | | | | |
| <input type="checkbox"/> Class 2 – Medium activity – exert occasional 20 to 50 lbs – force and/or 10 to 25 lbs force frequently | | | | |
| <input type="checkbox"/> Class 3 – Slight limitation, capable of light work – exert occasional 20 lbs force and/or up to 10 lbs force frequently | | | | |
| <input type="checkbox"/> Class 4 – Moderate limitation, capable of sedentary, clerical or administrative work – occasional 10 lbs force, mostly sitting | | | | |
| <input type="checkbox"/> Class 5 – Severe limitation, incapable of minimal activity or sedentary work <input type="checkbox"/> Bed confined <input type="checkbox"/> 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 | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Is patient able to work with job modifications? | Date patient able to work | Remarks and/or treatment plan | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time | | | |
| Name of attending physician (please print) _____ State Physician Number and State of Licensure _____ Telephone Number _____ | | | | |

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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

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