Disability Benefits Claim Packet Instructions

INTERNATIONAL
A division of Morgan White Group

75 Valencia Avenue, Suite 801
Coral Gables, Fl 33134
Phone: (305) 442-0899
Fax: 305-442-0961
www.morganwhiteintl.com

Your Disability Benefit Claim

This packet contains the forms necessary to apply for disability benefits. Every space should be filled to avoid delay in processing your application. If a section does not apply, or information is not available, write "N/A" in the space so that we know you did not overlook the question. If a form is received incomplete, it may be returned for completion.

How To Apply For Benefits

The Disability Benefits application includes claim forms and an authorization.

1. The Applicant's Statement

- Answer every question completely. Be sure to use the appropriate section for injury or illness. If question does not apply to you, write "N/A".
- Use an additional page, if necessary, to give full and complete answers. Remember to sign and date your statement. An unsigned or undated statement will be returned to you.

2. The Authorization to Obtain and Release Psychotherapy Notes and Other Information

- If you have been treated by a psychiatrist, psychotherapist, psychologist, clinical social worker, etc., or received treatment for a mental health condition, please sign and return the Authorization to Obtain and Release Information form AND the Authorization to Obtain and Release Psychotherapy Notes.

  You will receive copies of these authorizations upon request.

3. The Attending Physician's Statement

- Part A should be completed by you.
- Part B should be completed by your physician. If you have seen more than one physician for your disability, a statement should be completed by each physician. You may request additional forms from the Administrator, MWG International. Your physician(s) should mail, fax, or email the completed form directly to MWG International.

4. To Report & File your Claim

Notice of a claim must be given within thirty (30) days from the onset of a disability or accident resulting in a disability.
The notice of claim must be in writing and may be submitted via fax, email, or regular mail to:
MWG International Morgan-White Administrators International Inc.
75 Valencia Avenue, Suite 801, Coral Gables, FL 33134
Fax No. (305) 442-0961, Email: intlclaims@morganwhite.com

You are responsible for making sure all required forms are completed and returned to our office.
If you have any questions, please contact our Customer Service Department at (305) 442-0899.

Initials: _____

1. Claimant

Full name		Height	Weight	Sex	DOB *(Day Month Year)*
Address	City		State		Zip
Policy number				Phone number	

2. Employment

Name of employer			
Address	City	State	Zip
Phone number			
State your job title and describe your duties at work			
Is your disability the result of a work-related injury or illness? ❑ Yes ❑ No	Date of injury or illness *(Day Month Year)*	Last full day at work *(Day Month Year)*	
Date you became unable to work at your occupation as a result of disability *(Day Month Year)*			
Are you currently working? ❑ Yes ❑ No *If yes, list names of employers, addresses, telephone numbers, and dates of employment*			
Are you self-employed at any activity? ❑ Yes ❑ No			
Date you resumed part-time work *(Day Month Year)*	Phone number	Extension	
Date you resumed full-time work *(Day Month Year)*	Phone number	Extension	

3. Illness *Please list all illnesses which contribute to your being unable to work at your occupation.*

Illness	Date first noticed *(Day Month Year)*
Illness	Date first noticed *(Day Month Year)*
State what you believe caused your illness(es)	
Symptoms	
Have you ever had the same condition or a related illness? ❑ Yes ❑ No	Date *(Day Month Year)*

4. Injury

Injury	Date *(Day Month Year)* and time	Location
Cause of injury		

Initials: _____

5. Attending Physician *List all physicians consulted for this injury or illness. Use separate sheet, if needed.*

Physician's name	Specialty		Phone number
Address	City	State	Zip
Fax number	Date first consulted for this injury or illness *(Day Month Year)*		Date last consulted *(Day Month Year)*
Physician's name	Specialty		Phone number
Address	City	State	Zip
Fax number	Date first consulted for this injury or illness *(Day Month Year)*		Date last consulted *(Day Month Year)*

6. Hospital *If you were hospitalized for this condition, please complete. Please attach copy of hospital bill if available.*

Ailment	Date *(Day Month Year)*	Physician's Name	Complete Address

7. Work Experience *Complete the following starting with your most recent work experience.*

Job title & employer	Dates of employment	Last salary
Duties		
Job title & employer	Dates of employment	Last salary
Duties		
Job title & employer	Dates of employment	Last salary
Duties		
Job title & employer	Dates of employment	Last salary
Duties		
Job title & employer	Dates of employment	Last salary
Duties		

I hereby certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the application fraud notice below.

Signature _____ Date _____ /_____ /_____
Day Month Year

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, or other persons, files a statement containing false or misleading information concerning any fact material, hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties.

Authorization to Obtain and Release Information

I authorize these persons having any records or knowledge of me or my health:

- Any physician, medical practitioner, or health care provider
- Any hospital, clinic, pharmacy, or other medical or medically related facility or association
- Any insurance company or annuity company
- Any employer, policyholder, or plan sponsor
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program
- Any educational, vocational or rehabilitation counselor, organization or program
- Any consumer reporting agency, financial institution, accountant, or tax preparer
- Any government agency

To give this information:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of physical or mental condition, including:
    - Any disorder of the immune system, including HIV, acquired immunodeficiency syndrome (AIDS) or related syndromes or complexes
    - Any communicable disease or disorder
    - Any psychiatric or physiological condition, and/or conditions, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date
    - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs
    - Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations

to MWG International ("Administrator") and their authorized representatives.

- I acknowledge that any agreements I have made to restrict my protected information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical records without restriction.
- I understand that each of the Companies and/or Administrator will gather my information only if they are administrating or deciding my disability claim(s), and will use the information to determine my eligibility or entitlement for benefits.
- I understand that I have the right to refuse to sign this authorization and the right to revoke this authorization at any time by sending a written statement to the Companies and/or Administrator, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or failure to sign the authorization, may impair the Companies and/or Administrators ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for disability benefits.
- I understand that in the course of conducting its business the Companies and/or Administrator may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that the Companies and/or Administrator will release information to my employer necessary for management, for return to work and accommodation discussions. I understand that the information disclosed to them pursuant to this authorization may be subject to re-disclosure with my authorization.
- I understand and agree that this authorization, which will be used to gather information, shall remain in force from the date signed below:
    - For the Companies , the duration of my claim(s) or 36 months, whichever comes first
    - For the Administrator, the duration of my claim(s) or 36 months, whichever comes first
- I understand and agree the Companies and/or Administrator may share information with each other regarding my disability claim(s), this authorization shall remain valid for the duration of my claim(s) or 36 months, whichever comes first.
- I acknowledge that I have read this authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (*please print*) _____ Policy number _____

Signature of claiment _____ Date _____ /_____ /_____
Day Month Year

If signature is provided by legal representative (e.g., Attorney-in-Fact, guardian or conversation), please attach documentation of legal status.

Authorization to Obtain and Release Psychotherapy Notes

I authorize these persons having any records or knowledge of me or my health:

- Any physician, medical practitioner, or health care provider
- Any hospital, clinic, pharmacy, or other medical or medically related facility or association
- Any insurance company
- Any organization or entity administering a benefit or leave program (including statutory benefits)
- Any educational, vocational, or rehabilitation counselor, organization or program
- Any government agency

To give this information:

- Notes recorded by a health care provider, who is a mental health professional, documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record

to MWG International ("Administrator") and their authorized representatives.

- I acknowledge any agreements I have made to restrict my protected information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical records without restriction.
- I understand each of the Companies and Administrator will gather my information only if they are administrating or deciding my disability claim(s), and will use the information to determine my eligibility or entitlement for benefits.
- I understand that I have the right to refuse to sign or revoke this authorization at any time by sending a written statement to the Companies and/or Administrator, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or failure to sign the authorization, may impair the Companies and/or Administrator's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for disability benefits.
- I understand that in the course of conducting its business, the Companies and/or Administrator may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand the Companies and/or Administrator will release information to my employer necessary for management, return to work, and accommodation discussions. I understand the information disclosed, pursuant to this authorization, may be subject to redisclosure with my authorization.
- I understand and agree that this authorization, which will be used to gather information, shall remain in force from the date signed below:
    - For the Companies, the duration of my claim(s) or 36 months, whichever comes first
    - For the Administrator, the duration of my claim(s) or 36 months, whichever comes first
- I understand and agree the Companies and/or Administrator may share information with each other regarding my disability claim(s) This authorization shall remain valid for the duration of my claim(s) or 36 months, whichever comes first.
- I acknowledge that I have read this authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (*print*) _____ Policy number _____

Signature of claimant _____ Date _____ /_____ /_____
Day Month Year

If signature is provided by legal representative (e.g., Attorney-in-Fact, guardian or conversation), please attach documentation of legal status.

Part A *To Be Completed By Patient*

Full name		Patient no.	DOB *(Day Month Year)*
Address	City	State	Zip
Policy number		Phone number	
Occupation		Employer	
Date I returned to work *(Day Month Year)*		Date I expect to return to work *(Day Month Year)*	

Part B *To Be Completed By Physician*

The purpose of this form is to help determine whether the clinical condition of your patient is disabling. Please provide documentation of functional impairment including laboratory data and results of special tests (X-rays, CAT scan, and EKG, etc.). Please attach copies of any pertinent surgical reports, hospital admittance history, physician discharge summaries, chart notes, and narrative reports. The patient is responsible for the completion of this form, without expenses, to the Companies and/or Administrator.
Form may be returned for unanswered questions.

B1. Information

Primary diagnosis		
Secondary diagnosis		
Other diagnosis related to this claim		
Symptoms		
Height	Weight	Pulse
Right arm BP	Left arm BP	Dominant hand ❑ Left ❑ Right

Is condition primarily related to	*If pregnancy*, expected delivery date *(Day Month Year)*
❑ Patient's employment	Actual delivery date *(Day Month Year)*
❑ Mental disorder	❑ Vaginal ❑ Caesarean section
❑ Alcohol or drug condition	Complications
❑ Pregnancy	Number of pregnancies Live births

B2. History *Attending Physician's Statement Continued*

If patient was referred to you, indicate by whom		
Has patient ever had same or similar condition? ❑ Yes ❑ No	If yes, indicate when	
Describe		
Date patient first consulted you for this condition *(Day Month Year)*	For any condition	
Date of subsequent treatment *(Day Month Year)*	Date of most recent visit *(Day Month Year)*	
If patient was hospitalized, please provide dates. *(Day Month Year)*	Admitted	Discharged
Name of hospital	Admitting diagnosis	Discharge diagnosis
Hospital address	City	State Zip

B3. Assessment *Attending Physician's Statement Continued*

Date you recommended patient should stop working *(Day Month Year)*	Why?
Describe the patient's physical, mental, and cognitive limitations and work activity limitations	
How long from today's date will the described limitations impair the patient?	
Is the patient competent to manage insurance benefits? ❑ Yes ❑ No *If no, is the patient competent to appoint someone to help manage the insurance benefits?* ❑ Yes ❑ No	

B4. Treatment *Attending Physician's Statement Continued*

Planned course of treatment. Please include expected duration, surgeries, therapy, etc.			
Medications prescribed: dosage, frequency and date of prescription(s)			
List other treating or referring physician. Continue on separate page, if necessary.			
Full name		Phone number	
Address	City	State	Zip
Full name		Phone number	
Address	City	State	Zip
What reasonable work or job site modifications could the employer make to assist the individual to return to work? Please specify.			

Assessment and treatment complicated by:

❑ Malingering

❑ Significant emotional or behavioral disorder such as: ❑ Depression ❑ Anxiety ❑ Hysteria

❑ Exaggeration, inconsistent findings, subject complaints out of proportion to objective findings, bizarre, or contradictory observations.

❑ Dependence on drugs/medication. Please specify

❑ Other, please describe

Initials: _____

B5. Prognosis *Attending Physician's Statement Continued*

Describe patient's condition since onset of symptoms ❑ Recovered ❑ Improved ❑ Unchanged ❑ Regressed		
When do you expect a fundamental or marked change in patient's condition? ❑ Never ❑ Condition expected to regress ❑ Condition expected to improve		
State anticipated date *(Day Month Year)*	Unable to determine date	Unable to determine, because of
Date of follow up *(Day Month Year)*	Remarks	

B6. Acknowledgment

I hereby certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Signature _____ Date _____ /_____ /_____
Day Month Year

Physician's name	Specialty	Phone number	
Address	City	State	Zip
Fax number	Email		

Any person who knowingly and with intent to injure, defraud, or deceive an insurance company, or other persons, files statement containing

false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties.