FAX: (801)538-0392

Claim for Loss of Time - Disability Income.. ❑
Claim for Supplemental Hospital Plan .... ❑

P.O. Box 510690 ● Salt Lake City, UT 84151-0690 ● (800)227-0251

THIS SECTION MUST BE COMPLETED AND SIGNED BY POLICYHOLDER IN EVERY CASE.

PART 1: POLICYHOLDER'S STATEMENT

1. Policyholder's Name ______________________ Policy Number ______________________
2. Address ____
   Street City State Zip
3. Patient's Name ______________ Social Security # ______________ Age ________
4. Patient's Employer ______________ Patient's Occupation ______________
5. If claim is for an injury, give date of injury ________ Hour ______ AM / PM Current Phone # ______________
   (a) WHERE ______________________________
   (b) HOW ______________________________
   (c) Give nature of injury ______________________________
   (cuts, bruises, sprains, etc. and part(s) of body affected)
6. If claim is not for an injury, give nature of sickness ______________________________
7. First date attended by physician for this illness or injury ______________________________
8. Was illness or injury in any way related to the patient's occupation? ❑Yes ❑No
   (a) Has claim been filed or will claim be filed under Workman's Compensation Law? ❑Yes ❑ No

DISABILITY INCOME BENEFITS PROVIDED BY THE POLICY, CANNOT BE ASSIGNED.

PART 2: REPORT OF DOCTOR OF MEDICINE

1. Patient's Name ______________________ Age ________ Sex ________
2. Name of physician ______________ Address ______________
3. If confined to HOSPITAL, give date entered ______________ Date Discharged ______________
4. Name and Address of Hospital ______________________________
5. Dates of Treatment ______________________________
6. Date of ORIGIN and onset of illness or impairment ______________________________
7. Please state precise NATURE, CAUSE and EXTENT of injury or illness ______________________________
   ____
8. **Diagnosis Code(s)** ______________________________
9. Was this disability caused by or in any manner related to or contributed to by:
   (a) Any Previous Condition ______ (b) Pregnancy ______ (c) Intoxicants or Narcotics ______ (d) Mental or Nervous Disorder______
   If so, give date(s) and details ______________________________
10. Did this illness or injury arise out of or in the course of patient's employment? ______________________________
11. Describe fully NATURE of treatment, SURGICAL OPERATION, or obstetrical procedure ______________________________
    ____
    Date of Operation ______________ Date of Childbirth ______________
    Fee for Surgery $ ______________ Fee for other treatment, or obstetrical procedure $ ______________
12. **DISABILITY -** Date patient last able to work ________ Date patient able (or expected to be able) to return to work ________

Date signed ____________ **Signature of Doctor of Medicine** ______________________________

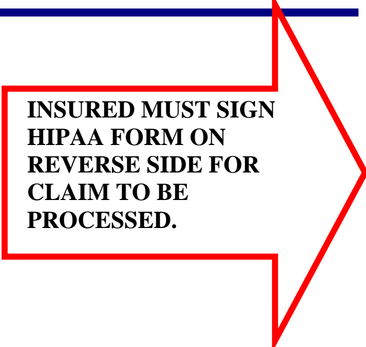
Mailing Address ______________________________
____
Where Graduated ______________ When ________

Individual Practitioner's Tax ID#______________________
All Others – Employer ID #: ______________________

PROCEDURE FOR FILING CLAIMS:

WHETHER HOSPITALIZED OR NOT:
PART 1, Policyholder's Statement, to be completed and signed by Policyholder.
PART 2, Doctor's Report, to be completed and signed by Attending Physician or Surgeon.

DISABILITY (TIME LOST FROM WORK)
If Doctor's Report indicates time lost from work due to a covered accident or sickness, we will promptly forward appropriate forms to employer for a report of the exact amount of time lost from work.



Form f2-45 REV. 1/96

P.O. Box 510690 ● Salt Lake City, UT 84151-0690 ● (800)227-0251

HIPAA Authorization for Release of Medical Information

______________________________ ______________________________

Name of Proposed Insured (please print or type) **Date of Birth**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, medications prescribed and any other protected health information concerning me to STANDARD LIFE AND CASUALTY INSURANCE COMPANY ("STANDARD LIFE"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis or treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that STANDARD LIFE may:

1. underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2. obtain reinsurance;
3. administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4. administer coverage; and
5. conduct other legally permissible activities that relate to any coverage I have or have applied for with STANDARD LIFE.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid ad the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above; I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that STANDARD LIFE has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by STANDARD LIFE except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for heath care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical records, STANDARD LIFE may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I or my authorized representative will receive a copy of this Authorization upon request.

Release all medical records to: Standard Life And Casualty Insurance Company
68 South Main Street, 5th Floor
Salt Lake City, UT 84101
(801)538-0376

______________________________ ______________________________

Signature of Proposed Insured or Personal Representative **Date**

____

Description of Personal Representative's Authority or Relationship to Patient