Educator Disability Claims

HOW TO FILE YOUR DISABILITY CLAIM

☐ SIGN and DATE this completed form, then submit using one of the methods shown below.

☐ The Authorization to Obtain and Disclose Information must be completed and signed.

☐ The Attending Physician's Statement must be completed and signed by the Attending Physician and submitted.

☐ Your employer must complete and submit Section C, the Employer Statement.

Mail To:

Chubb Workplace Benefits
Claim Department
PO Box 6700
Scranton, PA 18505-0700

Email to:
educatorclaims@chubb.com

Fax to:
312-351-7114

If you have any questions about the claim process or how to complete this form, please call 888-499-0425.

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

FRAUD NOTIFICATIONS

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

ARKANSAS, LOUISIANA, RHODE ISLAND, AND WEST VIRGINIA: 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.

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.

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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: 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 employee for the purpose of defrauding or attempting to defraud the policyholder or employee 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.

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

DISTRICT OF COLUMBIA: 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: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: 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.

FRAUD NOTIFICATIONS CONTINUED

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.

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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: 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: 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: 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: 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 defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties.

CHUBB

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

SECTION A — EMPLOYEE STATEMENT

PLEASE PRINT

FIRST NAME | LAST NAME | M.I.

E-MAIL ADDRESS: please provide your personal e-mail address and confirm if you agree to receive communications via your e-mail.
YES ☐ NO ☐

PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC. | HOME PHONE | MOBILE PHONE

MAILING ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY # | BIRTH DATE (MM/DD/YYYY) | HEIGHT (FT/IN) | WEIGHT (LBS) | MALE ☐ FEMALE ☐

POLICY NUMBER | MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ | IS SPOUSE EMPLOYED? YES ☐ NO ☐

NAME OF EMPLOYER (SCHOOL DISTRICT)

IS THIS DISABILITY DUE TO:
MOTOR VEHICLE ACCIDENT ☐ OTHER ACCIDENT ☐ SICKNESS ☐ WORK-RELATED INJURY/SICKNESS ☐ PREGNANCY ☐

IF PREGNANCY, PLEASE PROVIDE THE EXPECTED DUE DATE OF DELIVERY:

FOR ANY ACCIDENT RELATED CLAIM, PROVIDE AN EXACT DESCRIPTION OF WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF WHAT HAPPENED TO YOU

PLEASE SUBMIT A COPY OF THE POLICE REPORT RELATED TO YOUR ACCIDENT

NUMBER OF HOURS WORKED ON DATE LAST WORKED:	DATE YOU FIRST NOTED SYMPTOMS OF YOUR DISABILITY:	DATE YOU HAVE BEEN UNABLE TO WORK DUE TO THIS DISABILITY:	DATE RETURNED TO WORK? PART TIME: FULL TIME:	IF YOU HAVE NOT RETURNED TO WORK, WHEN DO YOU EXPECT TO RETURN? PART TIME: FULL TIME:

CHECK THE OTHER INCOME BENEFITS YOU ARE RECEIVING OR ARE ELIGIBLE TO RECEIVE AS A RESULT OF YOUR DISABILITY AND COMPLETE THE INFORMATION REQUESTED. IF YOU HAVE BEEN APPROVED OR DENIED FOR ANY OF THESE BENEFITS, PLEASE SEND A COPY OF AWARD OR DENIAL NOTIFICATION.

HAVE YOU FILED FOR SABBATICAL LEAVE? YES ☐ NO ☐
DO YOU INTEND TO FILE? YES ☐ NO ☐
IF FILED, HAS IT BEEN APPROVED? YES ☐ NO ☐
DATE PAYMENT BEGAN:
PAYMENT AMOUNT:

IF YOU WORK IN THE STATE OF LOUISIANA, HAVE YOU FILED FOR LA 90-DAY EXTENDED SICK LEAVE? YES ☐ NO ☐
IF NO, DO YOU INTEND TO FILE? YES ☐ NO ☐
IF FILED, HAS IT BEEN APPROVED? YES ☐ NO ☐
IF APPROVED:
DATE PAYMENT BEGAN:
PAYMENT AMOUNT:

OTHER LEAVE: YES ☐ NO ☐ IF YES, WHAT TYPE?
PAYMENT AMOUNT: WEEKLY ☐ MONTHLY ☐ OTHER ☐

HAVE YOU FILED A WORKER'S COMPENSATION CLAIM? YES ☐ NO ☐
DO YOU INTEND TO FILE A WORKER'S COMPENSATION CLAIM? YES ☐ NO ☐
IF FILED, HAS IT BEEN APPROVED? YES ☐ NO ☐
AMOUNT: DATE PAYMENT BEGAN:

HAVE YOU EVER BEEN EMPLOYED BY ANY OTHER SCHOOL(S) OR DISTRICT(S)? YES ☐ NO ☐
ANY AGE REPLACEMENT RELATED TO YOUR DISABILITY? YES ☐ NO ☐
PLEASE LIST NAME(S) OF SCHOOL DISTRICT(S) AND YEARS EMPLOYED:

TYPE	YES	NO	IF YES, PROVIDE AMOUNT	WEEKLY	MONTHLY	DATE BENEFITS BEGIN DATE	THROUGH DATE
SOCIAL SECURITY RETIREMENT	☐	☐		☐	☐		
SOCIAL SECURITY DISABILITY	☐	☐		☐	☐		
STATE DISABILITY	☐	☐		☐	☐		
TEACHER'S RETIREMENT - DISABILITY	☐	☐		☐	☐		
TEACHER'S RETIREMENT	☐	☐		☐	☐		
PUBLIC EMPLOYEE RETIREMENT	☐	☐		☐	☐		
PUBLIC EMPLOYEE DISABILITY	☐	☐		☐	☐		
PENSION/DISABILITY	☐	☐		☐	☐		
UNEMPLOYMENT	☐	☐		☐	☐		
OTHER:	☐	☐		☐	☐		

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

EMPLOYEE NAME	POLICY NUMBER

SECTION A (continued) — EMPLOYEE STATEMENT

YOUR OCCUPATION AND TITLE

LIST YOUR OCCUPATIONAL DUTIES AT THE TIME OF YOUR DISABILITY (GRADE LEVEL, PHYSICAL DUTIES, ETC.)

GROSS ANNUAL SALARY (DURING THE 12 MONTHS JUST PRIOR TO YOUR DISABILITY, FOR THIS EMPLOYER ONLY)	NUMBER OF HOURS YOU WERE REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER:	NUMBER OF REGULAR SICK DAYS ACCUMULATED:

IF YOU HAVE OTHER ACCIDENT-SICKNESS DISABILITY INSURANCE, GIVE COMPANY NAME, ADDRESS, AND BENEFIT AMOUNT. (IF NONE, STATE “NONE”)

INSURANCE COMPANY NAME

ADDRESS

CITY	STATE	ZIP

BENEFIT AMOUNT:	WEEKLY	BI-WEEKLY	MONTHLY

IF YOUR REQUEST FOR BENEFITS IS APPROVED, DO YOU WANT THE MINIMUM $88.00 PER MONTH WITHHELD FROM YOUR CHECK FOR FEDERAL INCOME TAX PURPOSES?
YES ☐ NO ☐

IF YOU WOULD LIKE MORE THAN $88.00 WITHHELD PLEASE STATE THE DOLLAR AMOUNT (TO THE NEAREST DOLLAR) YOU WANT WITHHELD MONTHLY:

LIST YOUR DEPENDENT CHILDREN WHO ARE UNDER AGER 25. (Attach additional sheets if needed)

NAME	BIRTH DATE (MM/DD/YYYY)	ATTENDING COLLEGE
		YES ☐ NO ☐
		YES ☐ NO ☐

CHUBB

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

EMPLOYEE NAME	POLICY NUMBER

SECTION A (continued) EMPLOYEE STATEMENT

PHYSICIAN AND HOSPITAL INFORMATION - To avoid delay in processing your claim, advise your Doctor(s) to attach copies of medical records and test results

FIRST MEDICAL ATTENTION FOR THE CURRENT DISABILITY WAS GIVEN BY:

PRIMARY ATTENDING PHYSICIAN'S NAME			SPECIALTY
ADDRESS			
CITY		STATE	ZIP
PHONE NUMBER	FAX NUMBER	INITIAL DATE OF TREATMENT (MM/DD/YYYY)	LAST DATE OF TREATMENT (MM/DD/YYYY)

LIST ALL OTHER PHYSICIANS AND HOSPITALS YOU HAVE SEEN FOR THIS CONDITION. IF THERE IS MORE PHYSICIAN OR HOSPITAL INFORMATION TO PROVIDE, PLEASE PROVIDE THE INFORMATION FOR EACH ON A SEPARATE PIECE OF PAPER AND INCLUDE WITH THIS FORM.

PHYSICIAN'S OR SPECIALIST'S NAME			SPECIALTY
ADDRESS			
CITY		STATE	ZIP
PHONE NUMBER	FAX NUMBER	INITIAL DATE OF TREATMENT (MM/DD/YYYY)	LAST DATE OF TREATMENT (MM/DD/YYYY)
HOSPITAL NAME			
HOSPITAL ADDRESS			
CITY		STATE	ZIP
PHONE NUMBER	FAX NUMBER	ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)

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.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

X______________________________ ______________ ______________________________
EMPLOYEE'S SIGNATURE DATE PLEASE PRINT NAME

I signed on behalf of the employee, as ______________________________ (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

SECTION B — ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME	LAST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)

EMPLOYER NAME (IF AVAILABLE)	POLICY(IES) NUMBER(S) (IF AVAILABLE)

DESCRIBE THE CONDITION

ICD 10 CODE	PRIMARY DIAGNOSIS
ICD 10 CODE	SECONDARY DIAGNOSIS

OTHER CONDITIONS	PATIENT'S HEIGHT	PATIENT'S WEIGHT	PATIENT'S BLOOD PRESSURE READING

WHEN DID SYMPTOMS FIRST APPEAR?	IF APPLICABLE, WHAT WAS THE ACCIDENT DATE?	HAS THE PATIENT EVER HAD THE SAME/SIMILAR CONDITION? ☐ YES ☐ NO IF YES, WHEN?

IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY OR COMPLICATION OF PREGNANCY: DUE DATE: DELIVERY DATE: ☐ NORMAL DELIVERY ☐ C-SECTION

ARE THERE ANY PRESENT COMPLICATIONS OR ANTICIPATED DIFFICULTIES IN CONNECTION WITH:
PREGNANCY? YES ☐ NO ☐ DELIVERY? YES ☐ NO ☐ POST-PARTUM? YES ☐ NO ☐
IF YES TO ANY OF THESE, PLEASE SPECIFY IN DETAIL:

TREATMENT REQUIRED

FIRST CONSULTATION	MOST RECENT CONSULTATION	NEXT CONSULTATION	RELEASED FROM CARE

WAS YOUR PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? IF SO, PLEASE ADVISE THE NAME AND PHONE NUMBER OF THAT PROVIDER.

IS/WAS DIAGNOSTIC TESTING PERFORMED? ☐ YES ☐ NO	TEST(S):	DATES

RESULTS

IS/WAS A SURGICAL OR MEDICAL PROCEDURE REQUIRED? ☐ YES ☐ NO	DATE	PROCEUDRE CODE

PROCEDURE

IS/WAS HOSPITALIZATION REQUIRED? ☐ YES ☐ NO	ADMISSION DATE	DISCHARGE DATE

HOSPITAL NAME

HOSPITAL ADDRESS	CITY	STATE	ZIP

WHAT IS THE CURRENT TREATMENT PLAN?

RESTRICTIONS, LIMITATIONS, AND ABILITY TO WORK

PLEASE PROVIDE SPECIFIC DETAILS AND DATES. RESPONSES SUCH AS "NO WORK", "TOTALLY DISABLED", "UNDETERMINED", OR "UNKNOWN" WILL NOT ENABLE US TO EVALUATE YOUR PATIENT'S CLAIM FOR BENEFITS AND MAY RESULT IN US HAVING TO CONTACT YOU FOR CLARIFICATION.

THE PATIENT IS ABLE TO WORK IN THE FOLLOWING CAPACITY
NO WORK ☐ SEDENTARY ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐ VERY HEAVY ☐

THE DATE YOU EXPECT THE PATIENT TO RESUME WORK DUTIES
PART TIME/PARTIAL DUTIES: FULL TIME/FULL DUTIES: ANY RECOMMENDED JOB MODIFICATIONS?

THE PATIENT IS UNABLE TO: STAND_____HRS ☐ SIT_____HRS ☐ WORK_____HRS ☐ LIFT_____LBS ☐ CARRY_____LBS ☐
DRIVE_____HRS ☐ PERFORM DATA ENTRY ☐ REACH ☐ KNEEL ☐ SQUAT ☐ CLIMB ☐ CRAWL ☐

PLEASE PROVIDE THE SPECIFIC RESTRICTIONS

PLEASE PROVIDE THE SPECIFIC LIMITATIONS

THE RESTRICTIONS AND LIMITATIONS ARE: TEMPORARY ☐ IF SO, HOW LONG? PERMANENT ☐

IS THE PATIENT COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS? YES ☐ NO ☐

ATTENDING PHYSICIAN VERIFICATION

I AM AWARE THAT IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE RELEVANT AND IMPORTANT. I CERTIFY THAT THE ANSWERS GIVEN ON THIS FORM ARE TRUE, COMPLETE, AND CORRECTLY RECORDED.

PHYSICIAN SIGNATURE	DATE (MM/DD/YYYY)

PRINT NAME	SPECIALITY	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

PHYSICIAN'S TAX ID NUMBER

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

CHUBB

SECTION C **EMPLOYER'S STATEMENT**

NAME OF EMPLOYEE

JOB TITLE:

IS THE EMPLOYEE ALSO A COACH? ☐ YES ☐ NO

IS DISABILITY DUE TO EMPLOYMENT? ☐ YES ☐ NO

POLICY NUMBER(S)

DIVISION NUMBER

EMPLOYEE'S SOCIAL SECURITY NUMBER AND/OR DATE OF BIRTH

REASON FOR STOPPING WORK
☐ RESIGNED ☐ LAYOFF ☐ DISABILITY
☐ DISMISSED ☐ FAMILY MEDICAL LEAVE OF ABSENCE
☐ RETIRED ☐ OTHER LEAVE OF ABSENCE
☐ SABBATICAL ☐ OTHER REASON:

DATE EMPLOYED (MM/DD/YYYY)

DATE INSURED (MM/DD/YYYY)

DATE LAST WORKED (MM/DD/YYYY)

DATE RETURNED TO WORK?
PART TIME: ☐
FULL TIME: ☐

IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK

IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE (MM/DD/YYYY)

IF THE EMPLOYEE HAS BEEN TERMINATED, PROVIDE DATE OF TERMINATION (MM/DD/YYYY)

DATE DISABILITY INSURANCE TERMINATED (MM/DD/YYYY)

REQUIRED NUMBER OF HRS. PER WEEK

AVERAGE MONTHLY EARNINGS IN EFFECT AT LAST ANNUAL ENROLLMENT DATE

DOES THE SALARY INCLUDE STIPENDS? ☐ YES ☐ NO

IS EMPLOYEE SUBJECT TO: ☐ FULL FICA TAX? ☐ MEDICARE PORTION ONLY?

PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (AS OF POLICY YEAR OF DISABILITY)

EMPLOYEE ☐ 100% ☐ OTHER:

IS EMPLOYEE CONTRIBUTION: ☐ PRE-TAX DEDUCTION? ☐ AFTER-TAX DEDUCTION?

EMPLOYER ☐ 100% ☐ OTHER:

EMPLOYEE ELIGIBLE FOR:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM	PAID WEEKLY	PAID MONTHLY
☐	☐	SICK PAY				☐	☐
☐	☐	SALARY CONTINUANCE BENEFITS				☐	☐
☐	☐	WORKERS' COMPENSATION				☐	☐
☐	☐	LOCAL, STATE OR NATIONAL ASSOCIATION OR SOCIETY DISABILITY INCOME PLAN				☐	☐
☐	☐	NO-FAULT				☐	☐
☐	☐	UNEMPLOYMENT COMPENSATION DISABILITY				☐	☐
☐	☐	SOCIAL SECURITY BENEFITS (DISABILITY OR RETIREMENT)				☐	☐
☐	☐	RETIREMENT INCOME (NORMAL, EARLY, OR DISABILITY				☐	☐
☐	☐	OTHER LTD/STD BENEFITS				☐	☐
☐	☐	OTHER (DESCRIBE)				☐	☐

PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTS TO THIS FORM:
- **The employee's Workers' Compensation claim(s) and Approval/Denial Notification. (If employee's Worker's Comp claim was denied, please include a copy of the denial with this claim form.)**

Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer portions of the claim form.
I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

NAME OF POLICYHOLDER (COMPANY)

PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE COMPLETING THIS FORM

EMPLOYER'S TAXPAYER ID NUMBER (EIN)
OR PUBLIC EMPLOYER SOCIAL SECURITY NUMBER

MAILING ADDRESS OF POLICYHOLDER (COMPANY)

SIGNATURE

CITY | STATE | ZIP

DATE

EMAIL ADDRESS

TELEPHONE NUMBER

FAX NUMBER

CONSENT TO ELECTRONIC TRANSACTIONS

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America, Combined Life Insurance Company of New York, and/or ACE Property & Casualty Insurance Company, each a Chubb Group Company ("Chubb"), of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be sent to the email address on file. This consent unless withdrawn applies to all transactions between you and Chubb.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed by calling Chubb Workplace Benefits at 833-542-2013 Monday through Friday between the hours of 7:00am to 6:00pm Central Time.

You have the right to receive communications from Chubb in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-833-542-2013, Monday through Friday between 7:30 am and 6:00 pm CST. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Chubb.

CONSENT TO ELECTRONIC TRANSACTIONS (CONTINUED)

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

Print Name ____

Signature____

E-mail Address ____

Date____

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

I (we) authorize Chubb Group Company (CHUBB), hereinafter called the COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our):

☐ Checking Account ☐ Savings Account

Indicated below and the depository names below, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

Depository Name:______________________ Branch:______________________

Address: ____

City: ______________________________ State: ________ Zip: ____________

Transit ABA #: ______________________ Account #: ______________________

This authority is to remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it.

Name:______________________________ Date of Birth:______________

Date: ______________Signed: ______________________________

Date: ______________Signed: ______________________________

(Both parties must sign on a joint account)

FOR DEPOSITS TO A CHECKING ACCOUNT PLEASE ATTACH A VOIDED CHECK.

FOR DEPOSITS TO A SAVINGS ACCOUNT PLEASE ATTACH A DEPOSIT SLIP.

CHUBB

Educator Disability • Chubb Workplace Benefits
Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700
Telephone 888-499-0425 • Fax 312-351-7114

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claim or Policy Number:____

Name: ____

Address: ____

City: ______________________________ State: _______ Zip: _______________

Birthdate: _____ /_____ /_____

This will authorize CHUBB to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, Employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated. I further authorize CHUBB to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

The information to be disclosed may include but is not limited to:

History of Present Illness
Operative Reports
Daily Doctor's Notes
X-Ray Reports
Consultant's Report
Pathology Reports
Past Medical History
Blood/Toxicology
Discharge Summary
Laboratory Results
Previous Admissions

The information is needed for the following purpose(s): Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will expire (24) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to CHUBB. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

X ______________________________ Date: ______________________
(Signature of Employee) (Must be filled in)

X ______________________________ ______________________
(Signature of Parent or Guardian) (Relationship to Patient if Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.