

LOSS OF TIME CLAIM STATEMENT GROUP INSURANCE

i. To be completed by insured

New Claim Claim already submitted

1. Full name of insured (please print) Male Female 2. Certificate no. 3. Date of birth 4. Marital status

5. Employer's name and full address 6. Occupation 7. Social Security No.

8. Nature of disability (if due to an accident, provide date, time, place, and circumstances of accident) 9. First day of total disability
10. If you have recovered or returned to work, give date.

11. For the period covered by this claim, have you received or are you claiming benefits under a Worker's Compensation Law or similar law?
Yes No (If yes, give details and forward a copy of the award or letter of denial, if applicable).

12. Are you now receiving state unemployment benefits? Yes No (If yes, from what date?)

13. I AUTHORIZE any physician, medical practitioner, hospital, pharmacy, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer, having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to *Charleston Southern University*, its legal representative or agency employed by the Company, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by *Charleston Southern University* to determine eligibility for benefits under an existing policy. Any information obtained will not be released by *Charleston Southern University* EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of this claim.

14. I certify to the correctness of these statements and agree to notify *Charleston Southern University* immediately if and when I recover or return to work.

Insured's signature _____
Address _____
City _____ State _____ Zip _____
Telephone _____
Date _____

I certify to the best of my knowledge that the information included on the form is a true and accurate statement of all material matters.

IMPORTANT

After the attending physician has completed Section 2 of this form, Please return the form to the employer/policyholder.

NOTICE

Any person who knowingly and with intent to defraud any insurance company, or any other person, files a statement of claim containing any materially false information; or conceals, for the purpose of misleading, information concerning any fact material hereto, may be subject to criminal prosecution and civil penalties.

II. HEALTH INSURANCE CLAIM-GROUP-DISABILITY INCOME

ATTENDING PHYSICIAN'S STATEMENT

Note to physician: Authorization to release information, signed by the insured, appears above.

1. Diagnosis and concurrent conditions (If diagnosis code other than International Classification of Diseases used, give name.)
2. Is condition due to injury or sickness arising out of: A. Patient's employment? Yes No B. Accident? Yes No
C. Pregnancy? Yes No If pregnancy, please give estimated conception date: delivery date:

3. Dates of services

4. Date symptoms first appeared or accident happened 5. Date patient first consulted you for this condition

6. Patient ever had same or similar condition? Yes No (If yes, when and describe) 7. Patient still under your care for this condition? Yes No

8. Patient was continuously totally disabled (unable to work) From _____ thru _____ 9. Dates hospitalized From _____ thru _____

10. If still disabled, date patient should be able to return To work 11. Do you believe the patient is competent to endorse? checks and direct the use of the proceeds thereof? Yes No

Date Physician's name (please print) Signature Degree Phone no.

Street Address City or Town State Zip

Employer: CHARLESTON SOUTHERN UNIVERSITY Date put in employees file: _____