

Equitable Reserve Association

A Not-For-Profit Fraternal Life Insurance Association, est. 1897

Instructions for Application for Disability Insurance Benefits & Authorization/Notice to Obtain Information

Please complete Forms 820A and 300 in order for us to obtain additional medical information in the consideration of your claim.

Mail completed form to:
Equitable Reserve Association
Attn: Claims Department
P.O. Box 448
Neenah, WI 54957-0448

Keep a copy of the completed form for your records.

Call the Claims Department at 1-800-722-1574 if you have any questions or concerns.



EQUITABLE RESERVE ASSOCIATION

116 S. Commercial Street • Neenah, Wisconsin 54956

FINANCIAL AND MEDICAL RECORDS AUTHORIZATION

(This authorization complies with the HIPAA Privacy Rule)

Purpose: Consideration of a Life Insurance or Disability Income Insurance Application
Give completed and signed copy to the proposed insured.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB) or health care provider that has provided payment, treatment or services to me ("My Providers") to disclose the entire medical record and any other protected health information concerning me to Equitable Reserve Association and their agents, employees and representatives. This includes information on the diagnosis and 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 do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by #164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Equitable Reserve Association, 116 S. Commercial Street, Neenah, WI 54956, Attention: New Business Department. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that Equitable Reserve Association has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Equitable Reserve Association will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Equitable Reserve Association may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative

Date

SSN of Proposed Insured _____

Date of Birth of Proposed Insured _____

Address _____

**APPLICATION FOR
DISABILITY BENEFITS**

**Equitable Reserve Association
A Fraternal Benefit Society**

**116 S. Commercial Street
Neenah, Wisconsin 54956**

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.

IMPORTANT: For your disability coverage submit this form within 20 days after the start of your disability. It is your responsibility to have this form completed in full without cost to the Association. All questions must be answered in full and properly signed by you.

PART 1 STATEMENT OF THE INSURED

Name of Insured _____ Policy No. _____
Insured's Address _____ Assembly No. _____
City _____ State _____ Zip _____ Date of Birth _____
Home Phone _____ Right or Left Handed _____ Height & Weight _____
Name of Employer _____ Occupation _____ Date Employed _____

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- 1 a. Name of sickness _____
b. Describe symptoms. _____
c. Date first symptoms noticed? Date _____, _____.
d. Have you ever had this or similar sickness before? If yes, when? Yes No Date _____, _____.
e. State what you believe caused your sickness. _____

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- 2 a. Date and hour of accident? Date _____, _____ Hour _____ AM PM
b. What injuries were received? _____
c. Where were you when injured? _____
d. What were you doing? _____
e. What caused your injury? _____

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- 3 a. Date and name of first doctor consulted. Date _____, _____ Name _____
b. Name and address of all other doctors consulted. _____
c. Between what dates have you been confined to a hospital? From _____, _____ Hour _____ AM PM
To _____, _____ Hour _____ AM PM
Name and address of hospital. _____

4. List all sicknesses and injuries for which you have been treated during the past five years. Give dates, names, and addresses of doctors. _____

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5. a. Date Sickness/Injury cause you to quit work entirely. Date _____, _____ Hour _____ AM PM
b. Date you were first able to do any part of your work supervisory or otherwise?
Date _____, _____ Hour _____ AM PM
c. Date you were able to resume your regular work. Date _____, _____ Hour _____ AM PM
d. State any part of your work you could not perform during any period you were partially disabled. _____

6. Name all other organizations (including Workman's Compensation) in which you are insured for this disability.

Please give dates of policies and benefits paid. _____

I certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief.

_____ Date

_____ Signature of Policyowner

PART 2 STATEMENT OF THE EMPLOYER

This statement must be signed by the employer or an authorized delegate of the employer. If the insured is self-employed, the insured will complete the following statements giving all the details.

1. Occupation of the insured at the time of disability?

2. Employed how many days per week?

6. Occupation in which the insured returned?

3. Average monthly earnings?

7. Has employee requested unemployment benefits? _____
Does employee have group income protection? _____

4. Date employee last worked? AM
_____ Hour _____ PM

Date _____
(Company Name)

5. Date employee returned to work? AM
_____ Hour _____ PM

Address _____

(Signature) (Official Position)

PART 3 ATTENDING PHYSICIAN'S STATEMENT

It is the responsibility of the policyholder to have this claim form completed in full without cost to the Association. All questions on this form relate directly to the insuring provisions of the contract and therefore must be completed in full. Payment of approved benefits will not exceed the date this report is completed. Please return this form direct to Equitable Reserve Association.

Name of Patient _____ Date of Birth _____
 Mo. Day Year
 Is Patient Retired? Yes No Patient's Sex Male Female
 Employer Name _____

1. History

- a. Is this condition the result of: Accidental Injury? _____ or Sickness? _____
 b. When did symptoms first appear or accident happen? Date _____, 20____
 c. Date patient ceased work because of disability. Date _____, 20____
 d. Has patient ever had same or similar condition? Yes No If "Yes", state when and describe. _____

 e. Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
 f. Names and addresses of other treating physicians or facilities who may have rendered treatment. _____

2. Diagnosis (including any complications)

- a. Date of last examination. Date _____, 20____
 b. Diagnosis (including any complications) _____
 c. Subjective symptoms _____
 d. Objective findings (including current X-rays, EKG's, Laboratory Data, and any clinical findings) _____

3. Dates of Treatment

- a. Is patient still under your care for this condition? Yes No
 b. Date of first visit. Month _____ Day _____ Year _____
 c. Date of last visit. Month _____ Day _____ Year _____
 d. Frequency. Weekly Monthly Other (Specify)

4. Nature of Treatment (Including surgery and medications prescribed, if any)**5. Prognosis**

- a. Is patient now totally disabled? Patient's Job Any Other Work
 Yes No Yes No Yes No

b. What duties of patient's job is he/she incapable of performing?

	Patient's Job	Any Other Work
Do you expect a fundamental or marked change in the future?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
How long was or will patient be continuously totally disabled (unable to work)?		
From _____ 20____ To _____ 20____		
How long was or will patient be partially disabled?		
From _____ 20____ To _____ 20____		

6. Is Patient requesting benefits for loss of income from:
Social Security, and other government unit, or other insurance organization? Yes No

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

(Signature of Physician)

(Date)