Nippon Life Benefits®

Nippon Life Insurance Company of America
P.O. Box 2312
Mt. Clemens, MI 48046
claims-lifeanddisability@nipponlifebenefits.com
Phone: 1-800-374-1835
FAX 1-847-615-3122

Disability Claim Form

Instructions

Please send this form to the address or FAX number above. If you have questions concerning completion of this form, please call 800-374-1835.

1. This form should be completed **in its entirety** by the employer, the insured/claimant and attending physician.
2. If you have any additional information you feel would help in the review of this claim, please attach to this form.
3. The authorization to release medical information (Page 4) must be completed for all claims and returned with the other sections.
4. Please include a photocopy of the insured/claimant's driver's license or other photo ID.
5. If disability is due to an auto accident, include a copy of the police report and provide the auto agent's carrier name and phone number.

Employer Statement

Type and amount of benefit being claimed (please fill in all that apply):

Life coverage during disability $_____ Short term disability $_____ Long term disability $_____

Employee's name _____ I.D. number _____

Employee's address _____ Phone number _____

Employee's job title _____ Date in job _____

Please attach a copy of employee's job description to this completed form.

Employee hours worked per week _____ Date of employment _____

Effective date of employee's coverage _____ Date employee last worked _____

# of hours worked on date last worked _____

Percentage of premium paid by employer* _____% If less than 100%, were premiums paid with employee's pre-tax dollars? ☐ post tax? ☐

***See Internal Revenue code Section 105(a) and Regulations thereunder.**

Reason stopped working ☐ illness ☐ injury ☐ other Was coverage in force when disability began? ☐ yes ☐ no

Has employee returned to work? ☐ yes ☐ no If yes, give date returned _____ Number of hours _____

Is disability due to employment? ☐ yes ☐ no If yes, date filed for Worker's Compensation _____

If approved, amount of compensation received $_____

(If Worker's Compensation approved or denied, please attach a copy of the award or denial letter with this claim.)

Name and address of Worker's Compensation carrier (if disability is work related): _____

Employee's salary $_____ ☐ hourly ☐ weekly ☐ monthly ☐ annually

If salary is not paid hourly, is this a base wage? ☐ yes ☐ no Are any commissions or bonuses included? ☐ yes ☐ no

Please specify the amounts that are commissions _____ or bonuses _____

Salary eff date _____ Any owner/partner salary? If yes, please designate amt or %. _____

If employee not paid by a standard wage, explain how they are paid. _____

Was salary continued after date last worked? ☐ yes ☐ no If yes, please provide date salary continuance did/will end: _____

If salary was continued, was the amount paid the same as salary reported? ☐ yes ☐ no If no, explain: _____

Please specify: ☐ salary continuance ☐ sick pay ☐ vacation ☐ PTO ☐ other _____

Is employee receiving State Disability Income? ☐ yes ☐ no If yes, amt received $_____ Eff date _____

Is employee receiving a pension benefit under a plan sponsored by you, the employer? ☐ yes ☐ no

If yes, amt received $_____ Eff date _____

Is employee receiving any income from other sources you are aware of? ☐ yes ☐ no

If yes, amt received $_____ Eff date _____

Type of income _____

Employer name _____ Plan number _____ Unit number _____

Date _____ By _____ Title _____

(signature)

Telephone number _____ FAX number _____ Email address _____

Employee Statement (Must be accompanied by the Authorization for Release of Personal Health and other Information on Page 4)

Your name _____ Date of birth _____ Soc Sec # _____

Your home address _____

(Street) (City) (State) (ZIP code)

Home telephone number _____ Work telephone number _____

Cellular telephone number _____ Your email address _____

Do you have other insurance with our company? ☐ yes ☐ no If yes, please list policy numbers: _____

Do you have other disability insurance with other companies? ☐ yes ☐ no If yes, provide the following:

Name of company	Policy number/policy date	Type of coverage	Benefit amount received per month

Date you became disabled _____ Is disability due to ☐ accident ☐ illness Please describe accident in detail,

Including date, time and place of occurrence. If illness, nature of illness and date _____

If disability is the result of a motor vehicle accident, have you applied for or are you receiving No Fault/Auto Insurance Income Replacement benefits?

☐ yes ☐ no If yes, date applied _____ Amt received $ _____ Freq of pmts _____

Please provide name, phone number and policy number of your auto insurance carrier: _____

Did disability result from employment? ☐ yes ☐ no Have you filed a Worker's Compensation claim? ☐ yes ☐ no

If no, please explain: _____

If yes, date filed for Worker's Compensation _____ If approved, amount received $ _____ Freq of pmts _____

(If Worker's Compensation is approved or denied, please attach a copy of the award or denial letter with this claim.)

Indicate if you have applied for or are receiving any of the following benefits, date applied and benefit amount if approved (please send copy of award letter or most recent **benefit** check stub.)

	Date	Amount	Type	Date	Amount
Social Security Disability/Retirement/Widows			State Disability		
Pension			Other Income		

Please list current or past employers and occupations within the past 2 years from the date disability began (use a separate sheet if necessary).

Describe which duties and activities you are unable to perform as a result of your disability and why:

List the number of hours you **currently** spend each day in the following activities:

Sitting _____ hrs/day Walking _____ hrs/day Lifting _____ hrs/day Average weight lifted _____ lbs

Standing _____ hrs/day Traveling _____ hrs/day Bending _____ hrs/day Maximum weight lifted _____ lbs

Names of doctors, practitioners and hospitals	Telephone number	Date confined/consulted	Reason for confinement/consultation

I declare that all the above statements on this form are true and complete to the best of my knowledge.

_____ _____

(Signature of employee) (Date)

I certify that I am a citizen of the following country:

_____ _____ _____

(Country) (Signature) (Date)

This completed form may be faxed to 1-847-615-3122.

Attending Physician's Statement

This completed form may be faxed to 1-847-615-3122.

To Be Completed By Physician – Please include office notes and test results from date of disability to present.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Patient's name	Date of birth	Social Security No.

Height	Weight	Blood Pressure (last visit)

1 Patient is/was unable to work due to : ☐ Injury ☐ Illness ☐ Pregnancy

2 Diagnosis (include complications and ICD 9)

For Normal Pregnancy, complete items 3-7, then skip to item 25

3 What is the expected date of delivery?	**4** Date First Treated	**5** Date Last Treated/Date of Delivery

6 Bed confined? ☐ yes ☐ no
From To

7 If patient has delivered, type of delivery
☐ Vaginal ☐ C-Section

For all conditions except Normal Pregnancy, complete the following items

8 When did symptoms first appear or accident happen?	**9** Date you advised patient to stop working	**10** Is condition due to injury or illness arising out of patient's employment? ☐ yes ☐ no

11 Has patient ever had same or similar condition? ☐ yes ☐ no If yes, state when and describe

12 Date of First Visit	**13** Date of Last Visit	**14** Frequency of Visits

15 Objective Findings (X-rays, EKG's, lab data and clinical findings)	**16** Subjective Symptoms

17 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency

18 Names and phone numbers of other physicians

19 Has patient been hospitalized? ☐ yes ☐ no If yes, give name and phone number of hospital
From: To:

20 Restrictions (what the patient **SHOULD NOT** do)	**21** Limitations (what the patient **CANNOT** do)

22 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis

I IV
II V
III

23 If this is a cardiac condition, what is the functional capacity? (American Heart Association)
☐ Class 1 – No Limitation ☐ Class 3 – Marked Limitation
☐ Class 2 – Slight Limitation ☐ Class 4 – Complete Limitation

24 Has maximum medical improvement been achieved? ☐ yes ☐ no
If no, when do you expect a fundamental change? ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ More than 6 weeks

25 If employer can accommodate patient's limitations and restrictions, is patient able to return to work? ☐ yes ☐ no If yes, what date could employment begin?

26 Is patient competent to endorse checks and direct the use of those proceeds? ☐ yes ☐ no

27 Physician Name (Please Print)	Degree

Specialty	Phone Number	FAX Number

Address	City	State	Zip Code

Signature (No Stamp)	Tax ID Number	Date
X		

Nippon Life Benefits

Authorization for Release of Personal Health and Other Information to Nippon Life Insurance Company of America

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan and its administrator, disability plan and its administrator, insurer, or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me to disclose my entire medical record to the Nippon Life Insurance Company of America (Nippon Life Benefits), its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Nippon Life Benefits. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information.

I understand that unless prohibited by state or federal law the protected health information is to be disclosed under this authorization so that Nippon Life Benefits may administer claims and determine or fulfill responsibility for coverage and provision of benefits, coordinate the provision of benefits under my medical and disability coverages, and conduct other legally permissible activities that relate to any coverage I have or have applied for with Nippon Life Benefits.

Also, I authorize the Internal Revenue Service, Social Security Administration, any state taxing authority and any employer, former employer, business associate or partners, insurance company, insurance support organization, Worker's Compensation or vocational or rehabilitation counselor or provider to give any information or record it has about me, my employment, employment history or income to Nippon Life Benefits.

The following groups of persons employed or working for Nippon Life Benefits may use my personal health and other information which is described above: employees of the claim or legal departments and any other personnel of Nippon Life Benefits, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have or have applied for with Nippon Life Benefits. This includes, reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, employer or former employer as needed to perform fiduciary responsibility under any benefit plan and, when required by law, to any other public or private entity or person.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. 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 at any time. The request for revocation must be in writing and sent to: Disability Claims, Life and Health Segment, Nippon Life Benefits, P.O. Box 2312, Mt. Clemens, MI 48046. I understand that a revocation is not effective if Nippon Life Benefits has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I authorize: _____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Release to: Nippon Life Benefits
P.O. Box 2312
Mt. Clemens, MI 48046

Specify Dates or date ranges: _____

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits, on my decision to sign this authorization; unless the authorization is sought for eligibility, enrollment, underwriting, risk rating determinations, or solely for the purpose of creating PHI for disclosure to a third party.

Claimant's signature: _____ **Date:** _____

Claimant's full name: _____ **Date of birth:** _____

Claimant's address: _____

Telephone number: (_____) _____ **Can confidential messages be left at this number?** ☐ **yes** ☐ **no**

Claim number: _____

If you are the representative of the member or the member's dependent (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the member's or dependent's behalf. Please include the proper documentation that attests to your ability to sign.

I certify that I am a citizen of the following country:

_____ (Country) _____ (Country) _____ (Country)

FLORIDA FRAUD - 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.

NEW YORK FRAUD - 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. Applicable to Accident and Health.

Claimant's signature: _____ Date: _____

Notice Requirements

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

ARIZONA FRAUD - 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.

CALIFORNIA FRAUD - 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 FRAUD - 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.

DISTRICT OF COLUMBIA FRAUD - 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.

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

KENTUCKY FRAUD - 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.

LOUISIANA FRAUD - 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.

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

OHIO FRAUD - Any person who, with intent to defraud or knowing that he or she 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 FRAUD – 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 FRAUD - 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.

TENNESSEE FRAUD - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

TEXAS FRAUD - 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 FRAUD - Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

WASHINGTON FRAUD – 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.

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