Nippon Life Benefits®

Nippon Life Insurance Company of America
P.O, Box 7948
Lake Forest, IL 60045-7948
claims-lifeanddisability@nipponlifebenefits.com
Phone: 1-800-374-1835
FAX: 847-615-3866

Continuance of Disability

Instructions

Please mail or FAX this completed form to the address or number above. Please call 1-800-374-1835 with questions on how to complete this form.
1. This form should be completed in its entirety by the insured/claimant and attending physician, including the authorization to release information (Page 2).
2. To avoid an interruption in benefits, please answer all questions completely and legibly.
3. If you have any additional information you feel would help in the review of this claim, please attach to this form.

Statement of Insured

Your name _____ Date of birth _____ Soc Sec # _____

Your address _____
(Street) (City) (State) (ZIP code)

Home telephone number _____ E-Mail Address _____

Cellular telephone number _____ Website Address _____

Have you been continuously unable to perform any work since you became disabled? ☐ yes ☐ no

If no, please list all current or past employers since becoming eligible for disability benefits under our policy (use a separate sheet if necessary):

_____

Has your marital status changed? ☐ yes ☐ no If yes, ☐ married ☐ divorced ☐ widow/widower

Do you have any dependents other than your spouse? ☐ yes ☐ no

Indicate if you have applied for or are receiving any of the following benefits, date applied and benefit amount if approved. Other income sources include, but are not limited to, unemployment benefits, part or full-time work, internet business/sales, and other group disability income.

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

If Other Income is noted, please identify type (use as 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 spent 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	Date confined/consulted	Reason for confinement/consultation

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for **accident and health** 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.

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

_____ _____
(Signature) (Date)

Nippon Life Benefits®

Authorization for Release of Personal Health and Other Information to Nippon Life Benefits

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 re-disclosure. 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 7948, Lake Forest, IL 60045-7948. 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 understand that if I refuse to sign this authorization to release my complete medical record, Nippon Life Benefits may not be able to process my application for life or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon your request, a copy of this completed authorization will be provided to you. Any alteration of this form will not be accepted.

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) _____ (Signature) _____ (Date)

DISABILITY CLAIM FORM

Attending Physician's Statement (page A). Please fully complete this form. If incomplete, we will call for omitted information.

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 do not provide any genetic information when responding to this request for medical information.

Patient's name	Social security number	Date of birth

Physician's name (please print)	Degree	Specialty

Physician's street address

City	State or province	ZIP code

Tax ID number _____ Physician's phone number _____ Physician's FAX number _____

DIAGNOSIS

ICD-9 diagnosis code: _____ Blood pressure reading _____/_____ Date of reading _____

Patient's height _____ Patient's weight _____

Diagnosis (including any complications)

Subjective symptoms

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

Is patient ☐ ambulatory? ☐ house confined? ☐ bed confined? ☐ hospital confined?

Do you believe the patient is competent to endorse checks and to direct the use of those proceeds? ☐ yes ☐ no

Is condition due to injury or sickness arising out of patient's employment? ☐ yes ☐ no ☐ unknown

HISTORY

What date did symptoms first appear or accident happen? _____

Has patient ever had same or similar condition? ☐ yes ☐ no

If yes, please provide dates and describe past treatment, including any surgical procedures: _____

NATURE OF TREATMENT (Including any type and date of surgery and medications prescribed if applicable) CPT-4 code: _____

Date of first visit _____ Date of last visit _____ Date of next visit _____

Frequency of visits ☐ weekly ☐ monthly ☐ other (specify) _____

Has patient been hospitalized? ☐ yes ☐ no If yes, name and address of hospital and date(s) of confinement:

CARDIAC (if applicable)

Functional capacity (American Heart Association) ☐ class 1 (no limitation) ☐ class 2 (slight limitation)

☐ class 3 (marked limitation) ☐ class 4 (complete limitation)

METS (circle one) 1 2 3 4 5 6 7

OTHER PHYSICIAN INFORMATION

Was the patient referred to you by, or by you to, another physician? ☐ yes ☐ no If yes, please provide name and address of other physician:

Physician's name _____ Address _____

Attending Physician's Statement (page B). Please fully complete this form. If incomplete, we will call for omitted information.

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

☐ class 1 – no limitation of functional capacity; capable of heavy work* _____ no restrictions (0-10%)
☐ class 2 – medium manual activity* _____ (15-30%)
☐ class 3 – slight limitation of functional capacity; capable of light work* _____ (35-55%)
☐ class 4 – moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity _____ (60-70%)
☐ class 5 – severe limitation of functional capacity; incapable of minimal (sedentary*) activity _____ (75-100%)

Remarks:

MENTAL/NERVOUS IMPAIRMENT (if applicable)

☐ class 1 – patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ class 2 – patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ class 3 – patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ class 4 – patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ class 5 – patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Please define "stress" as it applies to this claimant.

What stress and problems in interpersonal relations has claimant had on the job?

Remarks:

PROGNOSIS

Does the patient's condition restrict employment activities? ☐ yes ☐ no
If yes, beginning on what date _____ end date _____
In an 8 hour day, patient can (restrictions/limitations):
Sitting _____ hrs/day Walking _____ hrs/day Lifting _____ lbs/max Bend/squat _____ hrs/day
Standing _____ hrs/day Traveling _____ hrs/day Pushing/pulling _____ hrs/day Crawl/climb _____ hrs/day
Explain the specific restrictions and limitations, including any other factors that may affect employment activities:

When will patient recover sufficiently to return to work:
☐ 1 month ☐ 1-3 months ☐ 4-6 months ☐ on _____ ☐ never
If never, please explain: _____

REHABILITATION

Is patient a suitable candidate for medical rehabilitation (i.e. cardiopulmonary program, speech therapy, etc.)? ☐ yes ☐ no
Is patient a suitable candidate for vocational rehabilitation? ☐ yes ☐ no
If yes, what specific restrictions and limitations would you place on vocational rehabilitation?
Date trial employment could begin? ☐ full-time ☐ part-time _____

Signature of physician _____ 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: 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: For your protection California law requires the following to appear on this form: 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.

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

Ohio: 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: 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.

Tennessee: 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: 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.