VENETIAN EMPLOYEE_01012025.

BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street · Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

FAMILY MATTERS. NO MATTER WHAT.®

DISABILITY CLAIM KIT
FOR FILING A SHORT OR LONG TERM DISABILITY CLAIM

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

Information requested in this kit is necessary to the speedy and accurate administration of your claim. If the claim form is not completed in full, determination of benefits could be delayed until all required information has been received. If a question does not apply, please write "NA" *(not applicable)* in those spaces.

There are three (3) primary sections to be completed in this kit:

Section 1: Employee Statement
Employee should fully complete this section.

Section 2: Employer's Statement
Employer should fully complete this section.

Section 3: Physician's Statement
Attending physician should fully complete this section.

A HIPAA-Compliant Authorization Form should also be fully completed by the insured and returned with this claim kit. This can be found on our website at www.bostonmutual.com.

If you wish to receive your proceeds via direct deposit to your banking account, please be sure to complete the enclosed EFT Authorization form and include it with your other claim paperwork when you send it in.

When all sections of this form have been completed, please send it to us at the address below.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Where to send Claim forms:

Boston Mutual Life Insurance Company
120 Royall Street · Canton, MA 02021
1-877-212-2950

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SECTION 1 – EMPLOYEE'S STATEMENT *(Please Print)*

Full Name *(Last, First)*	Gender ☐M ☐F	Date of Birth *(mo-day-yr)*	Social Security Number

Address *(City, State, Zip)*

Phone Number	Cell Phone Number	E-Mail Address

Marital Status	If married, spouse's name

List all Children *(Names and Dates of Birth)*

Date of Disability *(mo-day-yr)*	Occupation at time of disability	Is this accident or illness due to employment? YES☐ NO☐

Date you returned to work on a part time basis _____ *(mo-day-yr)* Date you returned to work on a full time basis _____ *(mo-day-yr)*

If you have not returned to work, when do you expect to return: Full time _____ *(mo-day-yr)* Part time _____ *(mo-day-yr)*

Describe how and where the accident occurred or describe the first symptoms of your illness:

Date first treated _____ *(mo-day-yr)* Treated by: _____ *(name and address)*

Have you ever had the same or similar condition in the past? YES☐ NO☐ If YES, please explain:

List all Treating Physicians/Hospitals for this accident or illness:

Name	Address	Date(s)

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SECTION 1 – EMPLOYEE'S STATEMENT . . . *cont. (Please Print)*

Are you now receiving, or do you expect to receive, or have you applied for:

			Amount	Begin Date	Termination Date
YES☐	NO☐	Social Security			
YES☐	NO☐	Worker's Compensation Benefits			
YES☐	NO☐	Pension or Retirement Benefits			
YES☐	NO☒	State Sick Plan			
YES☐	NO☒	Auto Ins. Wage Replacement			
YES☐	NO☒	Salary Continuation/Sick Pay			
YES☐	NO☒	Any Other Benefits *(specify)*			

• IF AN INSURANCE COMPANY PROVIDES ANY OF THE ABOVE BENEFITS, PLEASE COMPLETE ITEM BELOW •

Insurer Name: N/A

Address: _____ Type of Insurance: _____

If benefits are approved, do you want Federal Income Taxes withheld from your check? YES☐ NO☒

If yes, please state dollar amount you want withheld $_____ per week☐ per month☐

If benefits are approved, do you want State Income Taxes withheld from your check? YES☐ NO☒

If yes, please state dollar amount you want withheld $_____ per week☐ per month☐

Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Boston Mutual Life Insurance Company, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Boston Mutual Life Insurance Company to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Boston Mutual Life Insurance Company to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Boston Mutual Life Insurance Company to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Boston Mutual Life Insurance Company Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.

X _____ _____
Signature Date

EMPLOYEE #_____

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SSN:_____

SECTION 2 – EMPLOYER'S STATEMENT *(Please Print)*

Employee's Name *(Last, First)*	Policy No.	Division No. ||| ||| ||| |||	Insurance Class ||| ||| ||| |||

Occupation *(Please attach a copy of job description if available)*	Date of Hire	Employee's LTD/STD Effective Date	Employee's Premium Contribution
			% 100 ☐ Pre-Tax ☒ Post-Tax

Employee's Regular Work Schedule

_____ Days per Week _____ Hours per Day

☐ Full Time ☐ Part Time
☐ Exempt ☐ Non Exempt
☐ Seasonal

Salary Prior to Date Last Worked

Base Wages $
W-2 Earnings $
Overtime $
Commissions $
Bonus $

How was Employee Paid

☐ Hourly $ _____

☐ Salaried $ _____

Date of last pay increase: _____

Date Last Worked	Hours Worked that Day	Has employee returned to work? YES☐ NO☐	If YES, date _____ ☐Full TIme ☐Part TIme

Were there any changes to the employee's job responsibilities due to the medical condition before the employee stopped working? If yes, what were the changes and when were they made? YES☐ NO☐

Can the employee's job be modified to accommodate the disability either temporarily or permanently? If yes, please explain. YES☐ NO☐

Is it possible to offer the employee assistance in doing the job through use of technology or personal assistance for example? If yes, please explain. YES☐ NO☐

Is employee receiving or eligible to receive	YES	NO	Amount	Week	Month	Provider Name/Address *(if an insurer)*	**Date Benefits** Begin	End
Short Term Disability	☐	☐	$	☐	☐			
Salary Continuation/Sick Leave	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Auto Ins. Wage Replacement	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Worker's Compensation	☐	☐	$	☐	☐			
Has a Worker's Compensation Claim been filed?	☐	☐	If workers' compensation benefits have been denied, submit a copy of denial with the claim.					

Name and address of the employee's medical insurance carrier or HMO *(provide policy or ID No.)*

Do you have a pension plan? YES☐ NO☐	Is this employee eligible for your pension plan? YES☐ NO☐ If YES, when is employee eligible _____	What % does employee contribute? _____ %

Employer Name	Phone No.	Fax No.	
Address	City	State	Zip
Name of Person Completing this form	Title		
Signature *(The above statements are true and complete to the best of my knowledge.)*		Date	

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SECTION 3 – PHYSICIAN'S STATEMENT

Patient's Name _____

Patient is/was unable to work due to: *(check one)* ☐ Injury ☐ Illness ☐ Pregnancy EDC _____

Diagnosis *(include complications and ICD9)*	Is condition due to injury or illness arising out of patient's employment? YES ☐ NO ☐

Date you advised patient to stop working	Date of First Visit	Date of Last Visit

COMPLETE THE FOLLOWING ITEMS FOR NON-PREGNANCY RELATED CONDITIONS *(excluding Complicated Pregnancy)*

Has patient ever had same or similar condition? YES ☐ NO ☐ If YES, state when and describe

Objective Findings *(x-rays, EKG's, lab data and clinical findings)*	Subjective Symptoms
Nature of Treatment *(surgery, medications, etc.)*	Provide medication dosage and frequency

Has Patient been hospitalized? YES ☐ NO ☐

If YES, Name and Address of Hospital — Dates of Confinements

Restrictions and Limitations *(what the patient cannot do)*	Mental Impairment *(if applicable)* Provide 5 AXIS Diagnosis I ☐ IV ☐ II ☐ V ☐ III ☐

If this is a cardiac condition, what is the functional capacity? *(American Heart Association)*

☐ Class 1 – No Limitation ☐ Class 3 – Marked Limitation

Blood Pressure *(last visit)* Systolic/Diastolic _____ / _____ ☐ Class 2 – Slight Limitation ☐ Class 4 – Complete Limitation

Has maximum medical improvement been achieved? YES ☐ NO ☐ If no, when do you expect a fundamental change? *(please specify)*

When do you estimate patient will recover sufficiently to perform the duties of his/her occupation _____ *(mo-day-yr)*

When do you estimate patient will recover sufficiently to perform the duties of any occupation _____ *(mo-day-yr)*

If employer can accommodate patient's restrictions and limitations, is patient able to return to part time and/or light duty work?

☐ YES ☐ NO *(please explain)*

Remarks:

Physician Name *(please print)*	Degree	Specialty	
Address	City	State	Zip
Phone No.	Fax No.	Tax ID No.	
Physician's Signature *(The above statements are true and complete to the best of my knowledge – No Stamps Please)*		Date	

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Name: _____ Policy No: _____

Complete the information below to authorize Boston Mutual Life Insurance Company *("Boston Mutual")* to directly deposit your benefits into the bank account referenced below via Automated Clearing House (ACH)/Electronic Funds Transfer (EFT). A voided check or signed specification *(spec)* sheet/letter of instruction from the bank must be submitted with this form. Deposit slips and starter checks will not be accepted.

Bank Account Type: *(select one)* ☐ Checking Account ☐ Savings Account

Full Legal Name on Bank Account: _____

Name of Bank/Financial Institution: _____

Bank routing/ABA Transit # *(9 digits)*: _____

Account #: _____

This authority is to remain in full force and effect until Boston Mutual has received written notification from me of its termination in such time and in such manner as to afford Boston Mutual and the Bank/Financial Institution a reasonable opportunity to act on it.

Disclosures

- Boston Mutual shall incur no liability as a result of a deposit being dishonored by your bank.
- If Boston Mutual cannot make a deposit into the designated bank account via ACH/EFT for any reason, we reserve the right to mail a check to the claimant/beneficiary at the address of record.
- ACH/EFT is only available for U.S.-based banks or participating credit unions.
- It may take up to 2-3 business days from the date the disbursement is processed for your bank to reflect the deposit.

I authorize Boston Mutual to deposit funds into the designated bank account through an ACH/EFT. I agree that if there is an overpayment on my claim, I will promptly refund the full amount of any such overpayment by check.

Date: _____ Signature of Claimant/Beneficiary: X _____

Claim Services | ClaimsDept@bostonmutual.com

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BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* _____ Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also 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 such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

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 BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

X

Signature of Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient _____

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient _____

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured _____ Date _____