HELPING PROTECT WHAT YOU'VE ACHIEVED

QUESTIONS?
800-849-0474

INSTRUCTIONS: Print in black and initial all changes. Answer all questions in their entirety. Any unanswered questions will delay the processing "N/A" or "None" are unsatisfactory answers and will not be accepted.

Disability Insurance Claim Form

THANK YOU FOR NOTIFYING US OF YOUR CLAIM.

PLEASE ENSURE:

- You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim. If any question is not applicable please state 'N/A'.
- You have enclosed all requested information/ documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement

Policyholder/Insured:

FIRST NAME | M.I. | LAST NAME

Claimant/Insured Person:

FIRST NAME | M.I. | LAST NAME

Date of Birth:

MM | DD | YYYY

ACCIDENT OR SICKNESS DETAILS

A. Please give date of accident or first manifestation of illness:

B. If an accident, where the accident occurred:

C. If an accident, how the accident occurred:

D. The injuries sustained or illness which required treatment:

PLEASE PROVIDE DETAILS

E. Have you ever suffered from this type of injury or illness before?

PLEASE PROVIDE DETAILS

F. Have you previously claimed under this or a similar policy?

IF YES, PLEASE GIVE THE NAME, ADDRESS & POLICY NUMBER OF ANY OTHER INSURANCE THAT MAY COVER THIS INJURY.

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SPECIALTY INSURANCE, INC

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Disability Insurance Claim Form

The date you ceased working:

MM | DD | YYYY

The date you returned to work, or plan to:

MM | DD | YYYY

Did you attended a hospital? ☐ YES ☐ NO

NAME OF HOSPITAL

NAME OF DOCTOR OR CONSULTANT IN CHARGE

Date Admitted:

MM | DD | YYYY

Date Released:

MM | DD | YYYY

Was any period spent in intensive care? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS INCLUDING DATES:

Were you subsequently confined to your home on medical grounds? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS INCLUDING DATES & ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELEVANT:

Is there any additional information that you feel is relevant? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

DECLARATION

I declare that all the information given is to the best of my knowledge and belief, full, true, and correct. If any information supplied on this form is untrue I accept that my claim may be withdrawn and that no payment will be made to me.

Signature of Proposed Insured

Date (MONTH/DAY/YEAR)

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Disability Insurance Claim Form

This section must be fully completed by attending doctor. Any fee for completion of this section is the responsibility of the insured person.

DOCTOR STATEMENT

Patient's Information:

FIRST NAME ______ M.I. ______ LAST NAME ______

ADDRESS ______

CITY ______ STATE ______ ZIP CODE ______

Date of Birth:

MM ______ DD ______ YYYY ______

GENDER: ☐ MALE ☐ FEMALE

WEIGHT: ☐

HEIGHT: ☐

When did the patient first receive medical attention for this condition?

______

IF YES, PLEASE PROVIDE DETAILS:

______

Has the patient ever suffered with this or any similar condition before the present episode? ☐ YES ☐ NO

______

IF YES, PLEASE GIVE DETAILS INCLUDING DATES, TREATMENT & CONSULTATION:

______

Are you the patient's usual doctor? ☐ YES ☐ NO

______

IF NO, PLEASE GIVE NAME & ADDRESS OF USUAL DOCTOR:

______

On what date did incapacity commence?

MM ______ DD ______ YYYY ______

Is patient still incapacitated? ☐ YES ☐ NO

______

IF YES WHEN WILL PATIENT BE ABLE TO RETURN TO WORK? IF NO, WHEN DID INCAPACITY CEASE?

______

Was the patient hospitalized as a result of this condition? ☐ YES ☐ NO

______

PLEASE PROVIDE ANY DETAILS THAT ARE RELEVANT, INCLUDING HOW MANY DAYS PATIENT WAS HOSPITALIZED

______

______ **Signature**

______ **Name**

______ **Date** (MONTH/DAY/YEAR)

______ **Qualifications**

______ **Address + Telephone Number:**

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HIPAA Compliant Authorization for Release of Health Related Information

Name of Proposed Insured:

FIRST NAME | M.I. | LAST NAME

Date of Birth:

MM | DD | YYYY

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau or any other organization, institution or person that has any records or knowledge of me or my health, to give to International Specialty Insurance, any such information, to the extent permitted by law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or team trainer to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that International Specialty Insurance may: 1) work with underwriters to have the exclusions (if any) removed from my insurance policy; 2) conduct other legally permissible activities that relate to any coverage I have or have applied for with International Specialty Insurance.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand I have the right to revoke this authorization in writing, at any time, by providing written notification to International Specialty Insurance at 110 Oakwood Drive, Suite 420, Winston Salem, NC 27103. I understand that a revocation is not effective to the extent that any of my Providers has already relied on this authorization to disclose information about me.

I understand that any information that is disclosed is in pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by International Specialty Insurance except as authorized by me or as required by law. I understand that International Specialty Insurance may not be able to process my application if I refuse to sign this authorization, I further understand that if coverage has been issued, International Specialty Insurance may not be able to assist in removing medical exclusions placed on my insurance policy by underwriters or make any benefit payments, I understand that I or any authorized representative may receive a copy of this authorization upon request.

Signature of Proposed Insured/Patient or Date Personal Representative

Date (MONTH/DAY/YEAR)

Signature of Witness

Date (MONTH/DAY/YEAR)