



EMPLOYEE REQUEST FOR INFORMATION

Mail this completed form to:
 Aetna Life Insurance Company
 P.O. Box 14560
 Lexington, KY 40512-4560
 Phone: 866-326-1380
 Fax: 866-667-1987

This notice should be completed by Employer and Employee, using BLUE or BLACK ink, and faxed/mailed to Aetna Life Insurance Company in order to initiate a disability claim. Neither the furnishing of this form, nor its acceptance by the company, shall be construed as an admission of liability or a waiver of any of the provisions of the plan document.

| EMPLOYER INFORMATION (To be completed by the Employer.) | | | | | | |
|--|---|---|---|---|-----|-----------------|
| Employer's Name | | | | EIN Number | | |
| Employer's Address: Street | | | City | State | Zip | |
| Work Location (if different from the above) | | | | | | |
| Supervisor's name and telephone number | | | | | | |
| Does member have both Aetna Disability and Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | Aetna Disability Control Number | Disability Suffix | Disability Account | STD | LTD | Disability Plan |
| Complete all applicable information. | Aetna Health Plan Control Number | Health Plan Suffix | Health Plan Account | Health Plan Summary Code | | |
| Employee's Name (Last, First, Middle Initial) | | | Employee Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Employee's Social Security Number | | |
| Date of Hire (MM/DD/YYYY) | STD Coverage Effective Date (MM/DD/YYYY) | LTD Coverage Effective Date (MM/DD/YYYY) | Date Last Worked (MM/DD/YYYY) | Was more than a half day completed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Employee's Occupation | Occupation is: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy | | Date Salary continuation was paid through (MM/DD/YYYY) | Reason employee ceased work | | |
| Employee's earnings are: \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly | | | | Number of hours per week | | |
| If premium deductions are to be withheld please list the amounts (weekly) | | | The portion of the cost of coverage that is paid by the employee with post-tax dollars is non-taxable. What percentage of the cost of coverage is paid by the employee in this manner? | | | |
| | Amount | Pre-tax \$ | Post-tax | | | |
| Medical | \$ _____ | _____ % | _____ % | STD _____% LTD _____% | | |
| Life | \$ _____ | _____ % | _____ % | | | |
| Other | \$ _____ | _____ % | _____ % | | | |
| The following is applicable only if the employee also has group life insurance with Aetna: | | | | | | |
| Amount of Life Insurance Coverage Basic \$ _____ Supplemental \$ _____ | | | Type of Disability Coverage included with Life insurance <input type="checkbox"/> DBO-AID <input type="checkbox"/> PTD <input type="checkbox"/> Premium Waiver <input type="checkbox"/> SIB-PW | | | |
| Name and phone number of person providing the above information: | | | | Date (MM/DD/YYYY): | | |
| EMPLOYEE INFORMATION (To be completed by the Employee. Misrepresentation section on back page MUST be signed.) | | | | | | |
| Employee's Address: Street | | | City | State | Zip | |
| Telephone number | May we leave messages on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Date of birth (MM/DD/YYYY) | | |
| Date first missed work due to disability (MM/DD/YYYY) | | | Date returned/will return to work (MM/DD/YYYY) | | | |
| What is the nature of your disability (diagnosis and/or ICD/CPT Code)? | | | Were you hospitalized due to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what date were you hospitalized on? | | | |
| Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this condition the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this condition the result of a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| What is your occupation? | | Briefly describe your job duties | | | | |
| What is your doctor's name? | | What is your doctor's address and phone number? | | | | |
| Has your doctor recommended that you stay out of work because you cannot perform your job at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long do they expect you to remain out of work? | | | | | | |
| Briefly describe how your condition prevents you from working | | | | | | |
| Have you been disabled as a result of this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when and how long? | | | Are you receiving any other form of income? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe: | | | |

Employee's Name (Last, First, Middle Initial) REQUIRED

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

Employee's Signature

Date (MM/DD/YYYY)