EMPLOYEE'S STATEMENT OF CLAIM FOR LONG-TERM DISABILITY BENEFITS

MAIL FORM TO ⇒  **National Insurance Company of Wisconsin, Inc.**
Attention: Claim Department
250 South Executive Drive-Suite 300, Brookfield, WI 53005-4273

CONTACT US ⇒ **(800) 627-3660**

Directions for completing this form: Please complete this form in its entirety as this will allow us to best evaluate your claim, determine your eligibility for benefits, and develop a return to work plan. Failing to answer all questions may result in a delay of the processing of your claim. Although we have tried to allow for a sufficient amount of space to answer each question, if you need more space, please attach a separate sheet of paper.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony.

I. BACKGROUND INFORMATION

Your Full Name _____ Telephone # (_____)_____

Address _____Apt. #_____

City _____ State_____ Zip Code_____

Date of Birth _____/_____/_____ Social Security Number: _____ Gender: Male ☐ Female ☐

Marital Status _____ Has your marital status changed since the onset of your disability? Yes ☐ No ☐

If "Yes," please explain: _____

List Name and Birthdate of your Spouse and all Children under the age of 19:

_____

_____

II. EMPLOYMENT INFORMATION

Your Employer's Name _____ City _____ State_____

Occupation/Job Title _____

Base Annual Salary Immediately Before You Stopped Work (excluding overtime, bonus, etc.) $_____

Your Last Date At Work _____/_____/_____ (please report even if it was a partial day)

III. CLAIM INFORMATION

Has there been a change in your condition during the past 18 months? Yes ☐ No ☐

If "Yes," please describe the specific change(s) _____

_____

_____

Is your Claim related to an **injury**? Yes ☐ No ☐ If Yes, date and time of injury ____/____/_____ ____:____ a.m. p.m.

Describe how and where the injury occurred: _____

_____

Is your claim related to your occupation? Yes ☐ No ☐

If yes, have you filed a Worker's Compensation claim? Yes ☐ No ☐

If yes, what is the name, address and phone number of the representative that is handling your case?

_____

_____

_____

Name _____ **SSN:** _____
First **Middle** **Last**

Is your Claim related to an **illness**? Yes ☐ No ☐ If yes, date symptoms first appeared ____/____/_____

Describe the nature of your illness: _____

_____

Date you were first unable to work due to your illness or injury: ____/____/_____

Have you returned to work yet? Yes ☐ No ☐

If yes, part-time, date ____/____/_____ or full-time, date ____/____/_____

If you have not returned to work yet, when do you plan to return to your job, either on a full-time or part-time basis? Please explain in detail.

_____

_____

_____

Below, please describe other income/benefits you have received or are receiving.

Type	Amount	Date Began	Date Ended
Wages, Salary, or Remuneration received from **any employer**	$		
Wages, Salary, or Remuneration received from **self employment**	$		
Salary Continuation/Sick Leave Pay/Short Term Disability	$		
Social Security Disability	$		
Social Security Retirement	$		
State Disability or Retirement	$		
Retirement/Pension (normal, early, or disability)	$		
Workers' Compensation	$		
No-fault Automobile Insurance	$		
Group Disability Benefits	$		
Other (please describe) _____	$		

Have you, or do you plan to apply for benefits described above? _____

Type _____ Date application filed ____/____/_____

Type _____ Date application filed ____/____/_____

Type _____ Date application filed ____/____/_____

Please attach a copy of verification of any other benefits you are receiving, denial notice, or other correspondence explaining a decision received from the Social Security Administration, State Retirement Plan, or any other source.

Please describe the usual duties of your job/occupation: _____

_____

_____

Which of the above duties are you currently unable to perform? _____

_____

_____

Which of the above duties do you feel that you could still perform? _____

_____

Name _____ **SSN:** _____
First **Middle** **Last**

Do you feel you could return to your job or another job with your current employer, if accommodations were made? If so, please describe your accommodation needs: _____

_____

_____

Are there any concerns you have about returning to work? If so, please describe. _____

_____

_____

Have you attempted any type of work since you left your regular job (either for this employer, another employer or through self employment) since your disability began? Yes ☐ No ☐

If "No," do you expect to be engaged in any work activity in the future (including self employment)? Yes ☐ No ☐

If "Yes," provide name and address of employer: _____

_____

Anticipated number of hours per week and gross earnings _____

Essential Job Duties _____

_____

IV. MEDICAL INFORMATION

Please provide us with a brief description of your present condition(s). **Describe any physical and/or psychological limitations related to your work:**

_____

_____

_____

_____

_____

_____

Have you been hospitalized in the last 12 months? If so, please list *If you need more space, please attach a separate sheet of paper.*

Hospital Name: _____

Address: _____

Date of Admission ____/____/_____ Date of Discharge ____/____/_____

Physicians: Please list all Attending Physicians and Specialists whom you have seen and/or been referred to for your condition(s) along with their addresses & telephone numbers: *If you need more space, please attach a separate sheet of paper.*

Primary Attending Physician, address, & telephone number: _____

_____

_____

Other Physicians, address, & telephone numbers (seen in last 2 years): _____

_____

_____

_____

Name _____ **SSN:** _____
First **Middle** **Last**

Medication: Do you take medication for your condition(s)? Yes ☐ No ☐ Please include vitamins and/or other supplements

Medication	**Dosage**	**How Often Taken**	**Start Date**	**End Date**

If you need help taking medication, please explain: _____

_____

Testing: Please indicate any testing that has been performed in the last 12 months. (CT scan, MRI, stress test, physical/functional capacity evaluation, etc.):_____

_____

_____

V. DAILY LIVING ACTIVITIES

Please provide us with a detailed description of your daily routine *If you need more space, please attach a separate sheet of paper.*

_____

_____

_____

_____

Do you live alone? Yes ☐ No ☐ If no, who lives with you? (Names & relationship) _____

_____

_____

If you have family dependents, (e.g. children, parents) do they depend on you for care? If so, please explain:

_____

_____

_____

What is your present height? _____ weight? _____ Are you right handed or left-handed? _____

What time do you get up in the morning? _____ Go to bed? _____

Have there been any changes in your sleeping habits since your condition(s) began? Please describe: _____

_____

Have there been any changes in your ability to care for your personal needs and grooming? Please describe: _____

_____

Have your eating habits changed since your disability began? Please describe: _____

_____

Do you require assistance in preparing your meals? Please describe: _____

_____

Name _____ **SSN:** _____
First **Middle** **Last**

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, managing personal finances, or taking medication? Yes ☐ No ☐ Please describe: _____

_____

What type of housework do you perform? (Please circle all that apply)

Laundry … Vacuuming … Dusting … Washing Dishes … Mopping … Household Repairs …

Lawn Care … Snow Shoveling … Other _____

How often do you do this housework? _____

Have there been any changes in your ability to care for your household since your disability began? Please describe: ___

_____

_____

Have you experienced changes in your shopping habits? Please explain_____

_____

Do you drive? Yes ☐ No ☐

Do you take public transportation? Yes ☐ No ☐

If you need assistance when you travel, who goes with you and how are you helped? _____

_____

Have you continued or attempted any type of volunteer activity since you left work? Please describe: _____

_____

VI. INTERESTS, HOBBIES & SOCIAL ACTIVITIES

What kinds of interests, hobbies or activities do you participate in? (Please circle all that apply)

Bowling … Exercising … Fishing … Walking … Knitting … Watching Movies … Swimming … Sewing … Reading …

Watching TV … Using A Computer … Coaching … Playing Sports … Other _____

Have there been any changes in your participation level? Please describe: _____

_____

_____

Do you own a personal computer? Yes ☐ No ☐ If "Yes," please provide the following information:

What types of programs are you proficient in? Word ☐ Excel ☐ Other ☐ _____

Do you have an e-mail address? Yes ☐ No ☐ If "Yes," what is it? _____

If yes, may we contact you by using your e-mail address? Yes ☐ No ☐

Do you have your own web site? Yes ☐ No ☐ If "Yes," what is it? _____

VII. TRAINING, EDUCATION & EXPERIENCE

Please circle the highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

High School Diploma GED College Degree Graduate School

Degrees Received _____ Dates Attended _____

Major: _____ Minor: _____

Name _____ **SSN:** _____
First **Middle** **Last**

List any vocational or business courses attended:

School	**Program**	**Date Completed**	**Certificate/License Obtained**

Have you continued your education or vocational training since the onset of your "disability"? Yes ☐ No ☐

If yes, Name and address of the educational or vocational institution: _____

_____

Dates of Attendance _____ Courses of Study _____

Degrees or certificates received, if any, or expected to receive _____

Were you in the armed forces? Yes ☐ No ☐ Dates ____/____/_____ to ____/____/_____

Branch of Service _____ Highest Rank _____ Specialty _____

AUTHORIZATION

To all physicians and other medical professionals, hospitals, and other medical care institutions and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit administrators: You are authorized to provide National Insurance Company of Wisconsin, Inc., its affiliates and reinsurers, and any agent, benefit plan administrator, consumer reporting agency or independent claim administrator acting on behalf of National Insurance Company of Wisconsin, Inc. with information concerning medical care, advice, treatment, or supplies provided for the patient named below. I also authorize my employer, group policyholder, or benefit plan administrator to provide National Insurance Company of Wisconsin, Inc. with financial or employment-related information. This information will be used for evaluating a claim for benefits. I understand that the authorization is for the term of coverage of the policy or contract under which a claim for disability benefits has been submitted, and that it is valid for the duration of the claim. I also understand that I or my authorized representative may receive a copy of this authorization upon request. A copy of this authorization shall have the same authority as the original.

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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature: _____ Date: _____

Print Name: _____

Did anyone assist you in the completion of this form? Yes ☐ No ☐ If yes, please have them complete below.

Co-Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Please complete this form and return it to the address below as soon as possible, but no later than 30 days from the date of receipt. Failure to answer these questions, or sign the Authorization, may delay the initial decision or continuation of your benefits.

National Insurance Company of Wisconsin, Inc.
Attention: Claims Department
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
(800) 627-3660