

**Section 1 – To be completed by claimant** (Please print or type.)

Policy/Participation/Account no. - - \_\_\_\_\_

|   |                          |   |  |   |                             |  |
|---|--------------------------|---|--|---|-----------------------------|--|
| 1. Your name  |                          | 2. Address (street, city, state, zip)                 |  |   | 3. Date of birth            |  |
| 4. Home phone   |                          | 5. Social Security number                             | 6. Email address   |   | 7. Employer's name          |  |
| 7. Have you worked since becoming disabled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date:<br>Full- time _____ Part- time _____  |                          |   | 8. Do you expect to return to work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date:<br>Full- time _____ Part- time _____ |   |                             |  |
| 9. Are you receiving benefits from any of the following sources? If "Yes," indicate monthly amount.   |                          |   |  |   |                             |  |
|   | Yes                      | Current<br>Amount                                     | No   | If "No," have you made<br>application for this benefit? |                             |  |
| A. Social Security Disability   | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| 1. Primary  | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| 2. Dependent  | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| B. Public Retirement/Disability   | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| C. Railroad Retirement Act  | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| D. Workers' Compensation  | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| E. State Disability   | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| F. Wages, Salary or Commissions   | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| G. Social Security Retirement   | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| H. Pension/Retirement   | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| I. Other _____  | <input type="checkbox"/> | _____   | <input type="checkbox"/>   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No |  |
| If benefits from any of the above sources have been denied, forward a copy of the denial notice, and advise if you plan to apply for reconsideration for these benefits.  |                          |   |  |   |                             |  |
| 10. Since you became disabled, have you received or do you plan to receive any additional education or training?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain.  |                          |   |  |   |                             |  |
| 11. Are you receiving Vocational Rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                          |   |  |   |                             |  |
| A. If "Yes," is it provided by:   |                          |   |  |   |                             |  |
| <input type="checkbox"/> Workers' Compensation  |                          | <input type="checkbox"/> Long Term Disability carrier |  |   |                             |  |
| <input type="checkbox"/> State Department of Rehabilitation   |                          | <input type="checkbox"/> On your own                  |  |   |                             |  |
| B. Name, address and phone number of agency providing Vocational Rehabilitation:  |                          |   |  |   |                             |  |
| 12. Have you discussed returning to work with your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what did he/she advise?   |                          |   |  |   |                             |  |
| I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, law enforcement agency, educational institute, governmental agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I <b>UNDERSTAND</b> the information obtained by use of this authorization will be used by Union Security Insurance Company to determine eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information. |                          |   |  |   |                             |  |
| Signature of claimant _____   |                          |   |  | Date _____  |                             |  |

**After completion of Section 1, please forward the form to Attending Physician for completion of Section 2.**

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Please direct correspondence to:

**Assurant Employee Benefits** Regional Benefit Center PO Box 972030 El Paso TX 79997- 2030  
 T 800.283.3636 F 317.205.2201

