Supplementary Report for Benefits

ASSURANT Employee Benefits

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?
☐ Yes ☐ No If "Yes," on what date:
Full- time ______ Part- time ______

8. Do you expect to return to work?
☐ Yes ☐ No If "Yes," on what date:
Full- time ______ Part- time ______

9. Are you receiving benefits from any of the following sources? If "Yes," indicate monthly amount.

	Yes	Current Amount	No	If "No," have you made application for this benefit?
A. Social Security Disability	☐	______	☐	☐ Yes ☐ No
1. Primary	☐	______	☐	☐ Yes ☐ No
2. Dependent	☐	______	☐	☐ Yes ☐ No
B. Public Retirement/Disability	☐	______	☐	☐ Yes ☐ No
C. Railroad Retirement Act	☐	______	☐	☐ Yes ☐ No
D. Workers' Compensation	☐	______	☐	☐ Yes ☐ No
E. State Disability	☐	______	☐	☐ Yes ☐ No
F. Wages, Salary or Commissions	☐	______	☐	☐ Yes ☐ No
G. Social Security Retirement	☐	______	☐	☐ Yes ☐ No
H. Pension/Retirement	☐	______	☐	☐ Yes ☐ No
I. Other ______	☐	______	☐	☐ Yes ☐ 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?
☐ Yes ☐ No If "Yes," please explain.

11. Are you receiving Vocational Rehabilitation? ☐ Yes ☐ No
A. If "Yes," is it provided by:
☐ Workers' Compensation ☐ Long Term Disability carrier
☐ State Department of Rehabilitation ☐ On your own
B. Name, address and phone number of agency providing Vocational Rehabilitation:

12. Have you discussed returning to work with your doctor? ☐ Yes ☐ 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 Life Insurance Company of New York, or its representative, any and all such information. I **UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Life Insurance Company of New York 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 Life Insurance Company of New York 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.

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.

Union Security Life Insurance Company of New York
Administered by: **Assurant Employee Benefits** PO Box 972208 El Paso TX 79997- 2208
T 888.901.6377 F 866.439.1695

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Section 2 – To be completed by Attending Physician *(Please print or type.)*

History

Diagnoses | Subjective symptoms

Objective findings | Nature of ongoing treatment

Date of first visit ____________ Date of last visit ____________

Frequency: ☐ Weekly ☐ Monthly ☐ Other ____________

Has patient been hospital confined since last report? ☐ Yes ☐ No

Date(s) of confinement from ____________ to ____________

Name and address of hospital

Patient's Height ____________ Weight ____________

Cardiac

Complete only if applicable.

Functional Capacity (American Heart Association)

☐ Class 1 *(no limitation)* ☐ Class 2 *(slight limitation)* ☐ Class 3 *(marked limitation)* ☐ Class 4 *(complete limitation)*

Blood pressure *(latest reading)* ____________ as of *(date)* ____________

Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

Physical Impairment

Complete only if applicable.

Functional Capabilities:	☐ Unlimited	☐ Limited, but retains capacities to:	
Frequently lift and/or carry:	☐ No more than 10 lbs.	☐ 20 lbs.	☐ 50 lbs. Or more
Occasionally lift and/or carry:	☐ No more than 10 lbs.	☐ 20 lbs.	☐ 50 lbs. Or more
Stand and/or walk a total of:	☐ Less than 3 hours	☐ 4/6 hours	☐ 6/8 hours
(If marked limitation, describe degree.) ____________			
Sit a total of :	☐ Less than 3 hours	☐ 4/6 hours	☐ 6/8 hours
Push and/or pull (including hand or foot controls):	☐ Unlimited	☐ Limited	
Climbing	☐ Unlimited	☐ Limited	
Bending	☐ Unlimited	☐ Limited	
Stooping	☐ Unlimited	☐ Limited	
(If marked limitation, describe degree.) ____________			

Psychiatric Impairment

Complete only if applicable.

(a) Check appropriate response:

Judgement	☐ Obvious impairment	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ No deficits noted
Memory, short-term	☐ Deficits noted	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ No deficits noted
Memory, long-term	☐ Deficits noted	☐ Mildly impaired	☐ Moderately	☐ Severely	☐ No deficits noted
Confusion	☐ Severe	☐ Moderate	☐ Slight	☐ None noted	
Mood	☐ Depressed	☐ Neutral	☐ Cheerful	☐ Manic	
Affect	☐ Constricted	☐ Normal range			
Paranoia	☐ Severe	☐ Moderate	☐ Slight	☐ None noted	
Psychosis	☐ Hallucinations	☐ Delusions	☐ Thought Disorder	☐ Bizarre ideas	☐ No symptoms noted

(b) Do you believe this patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Work Capabilities

Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why.

When did these limitations apply? Began ____________ Ended ____________

When would you anticipate reduction of symptoms? ____________

Prognosis

Prognosis: ☐ Terminal ☐ Poor ☐ Good ☐ Excellent

Would any further therapy be reasonably expected to result in full or partial recovery?

☐ Yes *(Describe below.)* When ____________ ☐ No ☐ Unknown

Has patient reached maximum medical improvement? ☐ Yes ☐ No If "No," when ____________ ☐ Unknown

Return To Work Information

Has the patient been released to return to work at his/her occupation? ☐ Yes ☐ No ☐ Part time ☐ Full time

If "Yes", on what date ____________

Has the patient been released to return to work at any occupation? ☐ Yes ☐ No ☐ Part time ☐ Full time

If "Yes", on what date ____________

Rehab

Is patient a candidate for rehabilitation services? ☐ Yes *(Describe.)* ☐ No *(Explain.)*

Would job modification enable patient to work with impairment? ☐ Yes *(Describe.)* ☐ No

Would vocational counseling and/or retraining be recommended? ☐ Yes *(Elaborate.)* ☐ No

Name

Physician's name ____________ Degree/Specialty ____________

Street address ____________ CITY STATE ZIP CODE

Telephone no. ____________ Fax no. ____________

Signature ____________ Date ____________ DO NOT PRE-DATE ____________ PHYSICIAN'S EIN OR SSN

Patient ____________ Policy/Participation/Account no. - -