

WAIVER OF PREMIUM DISABILITY CLAIM PACKET

Your initial documents consist of 4 forms:

- HIPAA Compliant Authorization for Release of Medical Information
- Authorization to Obtain Information
- Member Statement
- Attending Physician's Statement

Instructions to Member:

- Answer all questions in full; date, sign and return the Member Statement and authorization forms.
- Provide the Attending Physician's Statement to your treating physician to complete.
- Advise Attending Physician to attach copies of laboratory reports, x-rays, diagnostic test reports and clinical notes covering the 12-month period preceding disability through the present.

HIPAA Compliant Authorization for Release of Medical Information

Print Name of insured/patient

Date of Birth

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to, pharmacies, pharmacy benefits managers, and insurers, medical facility, or other healthcare professional that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Great-West. This includes information on the diagnosis of treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

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, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West.

This authorization shall remain in force for 36 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Great-West has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Great-West except as authorized by me or as required by law.

I understand that "My Providers" may not refuse to provide treatment or payment for healthcare services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Great-West may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

Authorization to Obtain Information

I authorize these persons having any records or knowledge of me or my health:

- Any physician or medical practitioner
- Any hospital, clinic or other medical or medically related facility
- Any insurance company or reinsuring company
- Any employer or plan administrator
- Any government agency, i.e. Social Security Administration, Veteran's Administration
- Any consumer reporting agency
- Any organization providing me with income
- The Medical Information Bureau, Inc.

To give this information:

- All medical information on me, including medical history, diagnosis, prognosis and treatment of any physical or mental condition.
- Any non-medical information requested about me, including my education, employment history, or eligibility for other benefits or income.

To Great-West and/or its legal representatives, plan administrator or policyholder, or its authorized representative who is contracted by Great-West to assist in the evaluation of my claim:

I UNDERSTAND that Great-West will use this information to determine my eligibility for insurance benefits under an existing plan. Any information obtained will not be released by Great-West to any person or organization EXCEPT to reinsuring companies, or the persons or organizations performing business or legal services in connection with my claim.

I UNDERSTAND that this Authorization is valid for 36 months from the date signed.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photo copy of this Authorization shall be as valid as the original.

Print Insured's Name

Group Plan No.

Signature

Date

WAIVER OF PREMIUM INITIAL MEMBER STATEMENT

1. Name: _____ 2. ADA No. _____

Home

Address: _____

Home No. _____ Cell No. _____

Email: _____

Date of Birth: _____ Height: _____ Weight: _____ Right or Left Hand Dominant? _____

2. Dental Specialty or Occupation Prior to Disability :

General Dentistry Orthodontist Periodontist Dental Surgeon Other _____

3. Business Structure:

Sole Proprietor S Corp Partnership Regular Corporation Other _____

Employment Address: _____

Office No. _____ Fax No. _____

4. What is the nature of your present disability? _____

5. Is present condition due to an accident? Yes No Date of Accident: _____

Describe how and where accident occurred. If motor vehicle accident, attach a copy of the police/accident report. _____

6. Date you became disabled: _____ Date Last Worked: _____

Describe your work activities and schedule prior to disability. _____

7. Name and phone number of Primary Treating Physician: _____

8. When did you first receive medical treatment? _____

9. Have you ever been treated for the same or related condition(s)? Yes No

10. Have you been hospitalized for the same or similar condition in the past 12 months? Yes No

If Yes, please list name, phone number and address of hospital : _____

Date of Admission: _____ Date of Discharge: _____

11. List the names and addresses of all physicians or hospitals where you have been treated for the same or related condition(s):

Name	Telephone No.	Condition	Date of First Visit	Date of Last visit

12. How have your daily activities changed since becoming disabled? _____

13. Do you plan to return to dentistry? Yes No

If Yes, please indicate your anticipated return to work date: _____

14. Do you plan to return to any type of employment? Yes No

If Yes, please indicate your anticipated return to work date: _____

Other Comments: _____

Notice – Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.

Printed Name of Member

Member Signature*

Date

*If this form is signed by someone other than the Member, please provide description of relationship to Member.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Date of Birth: _____

Attending Physician Instructions:

- Complete Attending Physician's Statement
- Form must be dated and signed in physician's own handwriting
- **Attach copies of laboratory reports, x-rays, diagnostic test reports and clinical notes covering the 12-month period preceding disability through the present**
- Mail completed form and records to Great-West

HISTORY

Date symptom(s) first appeared or accident happened: _____

Date patient first consulted you for this condition: _____

From what date did you recommend patient cease work due to his/her condition? _____

Date of first visit: _____ Date of last visit: _____ Date of Discharge (if applicable): _____

Frequency of visits: Weekly Monthly Other

DIAGNOSIS (including complications)

Primary: _____

Secondary: _____

Please provide specific clinical findings to support diagnosis: _____

Please list any hospitalizations for the same or related condition(s) within the last 12 months, including name of hospital and admission/discharge dates: _____

TREATMENT

Recommended treatment and projected duration of treatment program: _____

Is patient following recommended treatment: Yes No If No, explain: _____

Date and description of surgery (if applicable): _____

Name and Telephone Number of Surgeon(s): _____

If disability is due to a CARDIAC CONDITION or VISUAL IMPAIRMENT, please complete the appropriate section below:

Cardiac

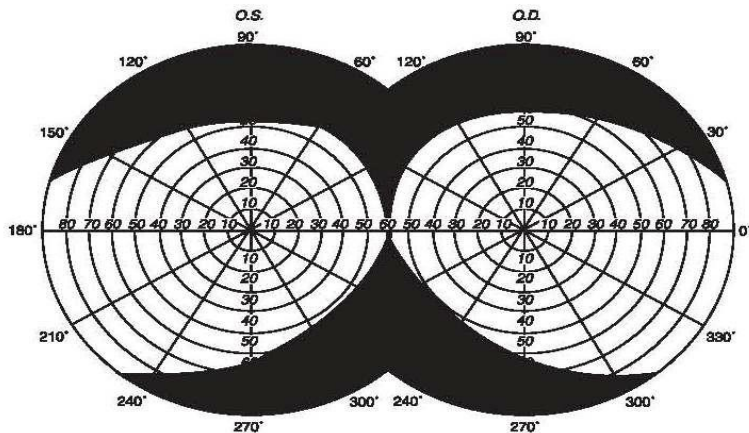
1. Provide blood pressure at last visit: _____
2. Functional capacity (American Heart Association) - Please mark one:

<input type="checkbox"/> Class 1 (No limitation)	<input type="checkbox"/> Class 2 (Slight limitation)
<input type="checkbox"/> Class 3 (Marked limitation)	<input type="checkbox"/> Class 4 (Complete limitation)
3. Is/Was patient in Cardiac Rehab Program? Yes No

Visual Impairment

1. Date of last vision examination: _____
 Without Glasses O.D. _____ O.S. _____
 With Glasses O.D. _____ O.S. _____

2. If fields of vision are contracted, show construction on chart below:



3. Vision can be restored in whole or in part by:

O.D. Lenses Operation Other Treatment Not Restorable

O.S. Lenses Operation Other Treatment Not Restorable

4. Date corrected vision was irrevocably reduced to 20/200 or less in the better eye: _____

PHYSICAL CAPACITY

How many hours in a normal work day can the patient stand/walk: 0-2 2-4 4-6 6-8+

How many hours in a normal work day can the patient continuously sit: 0-2 2-4 4-6 6-8+

Patient can lift/carry:	Never	Occasionally 1-2 hrs	Frequently 2-5 hrs	Continuously 5+ hrs
Up to 10 pounds 11-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient is able to:	Minimally	Occasionally	Frequently	Continuously
Stoop (bend at waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ascend, descend ladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ascend, descend stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient can use hands repetitively:	Minimally	Occasionally	Frequently	Continuously
Manual dexterity (hold, grasp, turn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger dexterity (pinch, pick, use keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is a formal Functional Capacity Evaluation necessary? Yes No

Please list all other functional considerations/limitations: _____

7. Do you believe these physical capacities to be permanent? Yes No

8. Do you believe your patient is capable of performing work outside of dentistry? Yes No

Please provide your Physical Impairment recommendations:

(*as defined in U.S. Dept. of Labor Dictionary of Occupational Titles)

- Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%)
- Class 2 - Medium/manual activity*(15-30%)
- Class 3 - Slight limitation of functional capacity, capable of light work* (35-55%)
- Class 4 - Moderate limitations of functional capacity; capable of administrative (sedentary*) activity (60- 70%)
- Class 5 - Severe limitations of functional capacity; incapable of minimal (sedentary*) activity (75-100%)
(*as defined in U.S. Dept. of Labor Dictionary of Occupational Titles)

PROGNOSISHas patient made significant progress? Yes No Please explain: _____

What changes do you expect in the near future? _____

When is maximum recovery expected? _____

What date do you expect to release patient to return to work in a part-time or full-time capacity?_____ **Part-Time** _____ **Full-Time****PSYCHOLOGICAL** (if applicable)

DSM-IV Multi-Axial Diagnosis

Axis I _____ Axis II _____

Axis III _____ Axis IV _____

Axis V: Current GAF _____ Highest GAF Past Year _____ Baseline _____

Subjective Symptoms: _____

How have the subjective symptoms been verified? _____

Objective Findings (please attach copies of any testing or clinical findings): _____

In your opinion, do the objective findings support the level of subjective limitations reported by your patient:

Yes No Please explain: _____

Complete the following Impairment Rating:

Degree of Impairment (0-None; 1-Slight; 2-Moderate; 3-Significant; 4- Severe)

Interpersonal relations	_____	Daily job activities	_____
Daily social activities	_____	Ability to think and reason	_____
Sustain work performance	_____	Concentration	_____
Present Memory	_____	Disturbance	_____
Judgment	_____	Suicidal ideation/intent	_____

Please describe Affect (e.g. appropriate, inappropriate; labile, stable, flat, etc.):

Are the patient's problems related to drug or alcohol abuse? Yes No

Specify any other factors which may have precipitated this condition and may affect prognosis for recovery:

 Attending Physician's Name (Please Print) Physician's Signature* Date

 Degree/ Board Certification Phone No. Fax No.

 Address City or Town/State or Province Zip Code

***Stamp or signature other than attending physician's own signature will not be accepted.**

NOTICE: Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states. Great-West Life & Annuity Insurance Company assumed no responsibility for any expense incurred in the completion of this statement. When completed, please mail this statement to Great-West.