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 Authorization for Release of Medical Information

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, or holders of prescription information on me, including but not limited to: pharmacies and pharmacy benefits managers, and insurers, medical facilities, or other healthcare professionals that have provided payment, treatment or services to me or on my behalf ("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 Life & Annuity Insurance Company (the Company). This includes information on the diagnosis or 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 Life & Annuity Insurance Company may: 1) evaluate my application for insurance coverage or claims benefits, determine eligibility and risk rating; 2) obtain reinsurance; 3) administer coverage and claims; 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West Life & Annuity Insurance Company.

This authorization shall remain in force for 30 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 Life & Annuity Insurance Company 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 Life & Annuity Insurance Company except as authorized by me or as required by law.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign the Authorization to release my complete medical record, Great-West Life & Annuity Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

Signature of Insured/Patient

Date of Signature

HIPAA 2017
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):

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone No.</th>
<th>Condition</th>
<th>Date of First Visit</th>
<th>Date of Last visit</th>
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</tbody>
</table>

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:
   □ Class 1 (No limitation)             □ Class 2 (Slight limitation)
   □ Class 3 (Marked limitation)       □ 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 □ 21-50 pounds □ 51-100 pounds

Patient is able to:
   □ Minimally □ Occasionally □ Frequently □ Continuously
   □ Stoop (bend at waist) □ Kneel □ Ascend, descend ladder □ Ascend, descend stairs
   □ Push/pull □ Reach above shoulder □ Crawl

Patient can use hands repetitively:
   □ Minimally □ Occasionally □ Frequently □ Continuously
   □ Manual dexterity (hold, grasp, turn) □ Finger dexterity (pinch, pick, use keyboard)

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)

PROGNOSIS
Has 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)

<table>
<thead>
<tr>
<th>Interpersonal relations</th>
<th>Daily job activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily social activities</td>
<td>Ability to think and reason</td>
</tr>
<tr>
<td>Sustain work performance</td>
<td>Concentration</td>
</tr>
<tr>
<td>Present Memory</td>
<td>Disturbance</td>
</tr>
<tr>
<td>Judgment</td>
<td>Suicidal ideation/intent</td>
</tr>
</tbody>
</table>

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.