GREAT-WEST FINANCIAL

Disability Income Plan
P.O. Box 17410
Denver, CO 80217-0410
1-866-257-0707 - Tel

DISABILITY INCOME INITIAL CLAIM PACKET

Submission Instructions

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.
- Provide a copy, including all schedules and W2s, of your individual and business Federal Income Tax Return, representing your highest net income in the four years just prior to your disability.
- Provide copies of your *individual monthly* production reports for the 24 month period just prior to the date you became disabled. Please ensure these reports include description of service with applicable Current Dental Terminology (CDT) Codes and charges for the services provided.

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

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INITIAL MEMBER STATEMENT – PLAN 1105

1. Name: _____ 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. Were your duties or work schedule impacted prior to your last date worked as a result of your disabling condition? ☐ Yes ☐ No If Yes, please indicate the date of impact and describe the changes._____

_____

_____

8. Have you returned to work in any capacity? ☐ Yes ☐ No

If Yes, please provide date of return along with current schedule and work activities. _____

_____

_____

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

_____

10. When did you first receive medical treatment? _____

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

12. 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: _____

13. 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

14. Do you have plans to close or sell your practice? ☐ Yes ☐ No

Date of sale: _____ Date of closure: _____

15. Do you have any other disability or office overhead expense coverage? ☐ Yes ☐ No

If Yes, please provide the following information:

Company Name	Telephone No.	Contact Person	Policy No.	Type of Coverage	Amount of Coverage

16. Indicate Other Sources of Income

	Receiving			Amount of Benefit			
	Yes	No		Weekly	Monthly		Start Date
Workers' Compensation							
State Disability							
State Unemployment							

17. Are you performing work outside of dentistry? ☐ Yes ☐ No

If Yes, as of what date? _____

Please describe the duties you are performing. _____

_____

_____

18. Do you plan to return to dentistry? ☐ Yes ☐ No

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

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.

_____

Print Name of Member Member Signature* Date

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

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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

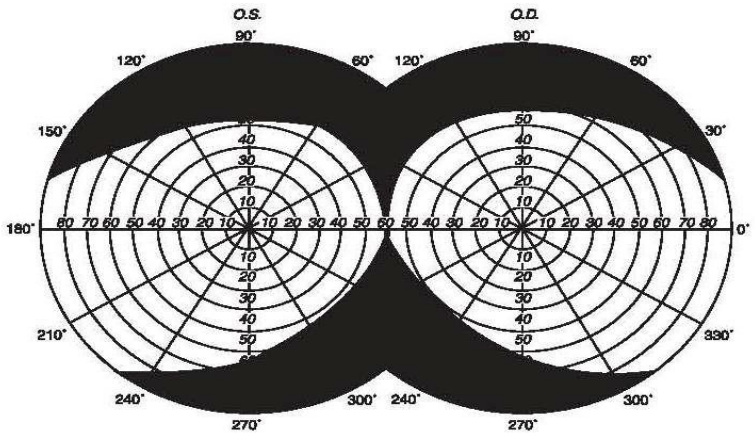
1. Provide blood pressure at last visit: _____
2. Functional capacity (American Heart Association) – Please mark one:
   - ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
   - ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
3. Is/Was patient in Cardiac Rehab Program? ☐ Yes ☐ No

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

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)

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 assumed no responsibility for any expense incurred in the completion of this statement. When completed, please mail this statement to Great-West.