aetna℠

Group Claim Form- Permanent & Total Disability – Life Insurance

Submit to: Aetna Life Insurance Company
PO Box 14548
Lexington, KY 40512-4548
Phone: 800-523-5065
Fax: 800-238-6239

Claimant

- **Claimant completes Sections 1 – 3 and signs the release in Section 3 and the bottom of Page 2.**
- **Please submit this form with a properly completed Attending Physician's Statement to the above address.**
- **Forms without signatures will be returned.**

Employer

- **Employer completes section 4.**
- **If the Claimant has Supplemental Insurance, you must submit the enrollment forms and/or screen prints for the current year as of date last worked and 2 years prior.**
- **Forms without signatures will be returned.**

1. Claimant Information

Employer Name				Work Location and/or Union affiliation
Claimant's Name		Birth date (MM/DD/YYYY)		Gender ☐ Male ☐ Female
Address (Street)	City	State	ZIP Code	Daytime Telephone Number ( )
Occupation		Cause of Disability		

2. Attending Physician Information (Attach additional sheet if more space if needed.)

Physician's Name		Condition(s) Treated		
Address (Street)	City	State	ZIP Code	Daytime Telephone Number ( )
Physician's Name		Condition(s) Treated		
Address (Street)	City	State	ZIP Code	Daytime Telephone Number ( )

3. Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original

Claimant Signature	Date

4. Employer Information

Basic Life Control Number	Control Suffix	Claim Account	Plan	Amount of Basic Insurance in Force on Date Last Worked $
Supplemental Life Control Number	Control Suffix	Claim Account	Plan	Amount of Supplemental Insurance in Force on Date Last Worked $

Claimant is ☐ Hourly ☐ Salary	Rate of Basic Earnings on Date Last Worked Annually $	Date Last Worked / /	Date Claimant First Began Work / /
Reason Claimant Did Not Return to Work After Last Day Worked			**Claimant's Social Security Number** – –

Type of Provision *(check one)*: ☐ Premium Waiver ☐ Lump Sum ☐ PTD/ Installment ☐ DBO-AID ☐ Group Universal Life	Date Insurance Took Effect / /	Effective Date Insurance Discontinued if Not in Force / /
Was Claimant Required to Submit Evidence of Insurability? ☐ No ☐ Yes, give date submitted _____	**Supplemental Insurance Required Information: Enrollment forms and/or Screen Prints for current year as of date last worked and 2 years prior.**	
Last Contribution Covered Period Ending ***(complete only if claimant contributed part of premium)***	**If Retired, Provide Retirement Date and Copy of Pension Acceptance**.	

Employer's Address (Street)	City	State	ZIP Code	Telephone Number ( )
Printed Name of Employer's Authorized Representative		E-mail Address		
Signature of Employer's Authorized Representative		Date / /		

Claimant's Name *(Last, First, Middle Initial)* **Required**

5. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents**: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas and Missouri Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. **Attention Louisiana Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention Maryland Residents**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention New Jersey Residents**: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents, the following statement applies only to your AD&D coverage**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents**: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I acknowledge that I have read the fraud notices above and I affirm that the answers on this form are complete and true to the best of my knowledge and belief.

Claimant's Signature	Date *(MM/DD/YYYY)*