EPIC SPECIALTY BENEFITS

P.O. Box 8430 – Madison, WI 53708-

Premium Waiver For Life Insurance

Diagnosis / Treatment / Diagnosis / Cardiac / Impairments / Prognosis / Rehab / Remarks / Signature

Name of Patient		Date of Birth	When did symptoms first appear or accident happen?
Date patient ceased work because of disability		Has patient ever had same or similar condition? Yes No If Yes, state when and describe	
Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown		Names and Addresses of Other Treating Physicians	
Diagnosis (including complications)		If pregnant, estimated date of delivery	
Subjective Symptoms		Objective Findings (including current x-ray, EKGs, lab data and any clinical findings)	
Date of First Visit	Date of Last Visit	Frequency: Weekly Monthly Other (specify)	

Nature of Treatment (including surgery and medications prescribed, if any)

Has Patient: Recovered Improved Unchanged Retrogressed	Is Patient: Ambulatory House Confined Bed Confined Hospital Confined

Has patient been hospital confined? Yes Confined from _____ through _____
No Name and Address of Hospital

Functional Capacity (American Heart Association) Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Complete Limitation)	Blood Pressure (last visit) Systolic/Diastolic _____

Physical Impairments (*As defined in the Federal 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 limitation of functional capacity: capable of clerical/administrative (sedentary*) activity* (60-70%)
- ☐ Class 5 – Severe limitation of functional capacity: Incapable of minimum (sedentary*) activity. (75-100%)

Remarks:

Mental Impairment (if applicable)

(1) Please define what "stress" is as it applies to this claimant
(2) What stress and interpersonal relations has claimant had on job?

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
- ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- ☐ Class 5 – Patient has significant loss of physiological, psychological, personal and social adjustment (severe limitations).

Remarks:

Is patient now totally disabled? Patient's job Yes No Any other work Yes No	Date patient became disabled due to present illness
When do you expect a fundamental or marked change? 1 Month 1-3 Months 3-6 Months Never Applies to: Patient's Job Other work	Please indicate patient's long and short-term prognosis (including life expectancy):
Is patient a suitable candidate for occupational rehabilitation? Patient's Job Yes No Any Other Work Yes No	Can present job be modified to allow for handling with impairment? Yes No

When could trail employment commence? Patient's Job Date _____ Full-Time Part-Time
Any Other Work Date _____ Full-Time Part-Time

Limitations, Therapy, etc.

Name of Attending Physician (please print) _____ Degree _____
Street Address _____ Telephone _____
City/Town _____ State or Province _____ Zip Code _____
Signature _____ Date _____

Statement of Claimant for Total Disability (Life Only)

Attending physician must complete and return the Attending Physician's Statement of Total Disability

1. Full Name:	2. Date of Birth:
3. Address:	4. Date Illness or Injury Began:
5. Nature of Disability:	
6. Give a full description of your illness or injury. (If an injury, please indicate how, when, and where your injury occurred.)	
7. Last date physically worked by reason of this disability:	8. What date did you first consult a physician for this disability?
9. Were you confined to a hospital? (If yes, please provide the name, address, and dates of stay.) ☐ Yes ☐ No	
10. Name(s) and address(es) of your treating physicians:	
11. If you are no longer totally disabled, what date did you return to work?	12. If you are currently disabled, what date do you expect to return to work?

I certify that the above statements are complete, true and correctly recorded. I hereby authorize any hospital, physician or any other institution or person who has attended or examined me to disclose to The EPIC Life Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I am willing to have a photocopy of this authorization be accepted with the same authority as the original.

Signature of Employee:	Date:

Statement of Employer for Total Disability (Life Only)

1. Policyholder	2. Address Street _____ City _____ State _____ Zip _____		
3. Policy #	4. Claimant's Certificate #		
5. Name of Claimant	6. Date of Birth	7. Age at Onset of Disability	8. Date Claimant Employed
9. Occupation	10. Salary	11. Amount of Insurance	12. Last Date Physically Worked by Claimant
13. Reason for Leaving Work			

I HEREBY STATE THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Name of Employer _____ Date _____

Signature _____ Title _____

Enclose a copy of enrollment card or Beneficiary Designation.

MAIL OR FAX FORM TO:

EPIC Speciality Benefit
ATTN: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-977-9861

Authorization to Disclose Health-Related Information

(This Authorization Complies with the HIPPA Privacy Rule)

I authorize any physician, healthcare professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Life"). "Information" may include my entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Life to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Life.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Life. I am aware that my revocation will not be effective until received by EPIC Life and will not be effective regarding the uses and/or disclosures of my Information that EPIC Life has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Life with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Life from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

Name of Claimant	Claimant's Date of Birth
Signature of Claimant or Personal Representative*	Date Signed

*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation)