www.dearbornnational.com

Partnership. Solutions. Strength.

WELCOME TO DEARBORN NATIONAL®

UNDERWRITTEN BY DEARBORN NATIONAL® LIFE INSURANCE COMPANY

Guide to Claims

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company, (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. Product features and availability vary by state and company, and are solely the responsibility of each affiliate.

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This guide is designed to assist you in the administration of your group insurance plan.

By providing accurate information and updating changes to the records that you provide to Dearborn National, we will establish a successful partnership in the administration of your plan.

A key identifier for all documents you send to Dearborn National is the group and account number. Please include these numbers on all communications.

We recommend that all persons involved in the administration of your group insurance plan familiarize themselves with all administrative procedures and forms. To understand the rights and obligations of all parties, refer to your group master policy.

SUBMITTING A CLAIM AND GETTING FORMS

SUBMITTING A CLAIM
Claims can be submitted by:

1. Mail the claim form to Dearborn National at the address listed on the form.
2. Fax the claim form to the number on the form.
3. Online at www.dearbornnational.com for Life, AD&D, Critical Illness or Waiver of Premium Claims. Please be prepared to attach the required documents when submitting claims online. Note: You must be a registered user of Benefit Manager.

GETTING FORMS
On our Web site, www.dearbornnational.com, you can obtain forms by clicking the "Forms" tab on our Home page and select Group Benefits. Follow the on-screen instructions.

Please complete the appropriate claim form for the type of claim being submitted. There are specific claim forms to be used when submitting Death/Accidental Death, Dismemberment, Accelerated Death Benefit, STD and LTD claims.

Most claim forms contain sections to be completed by the employer, the employee and the attending or treating physician. Note: All sections must be completed in their entirety, and appropriate signatures from the employer, employee and attending physician must be provided in order for the claim to be considered a complete claim submission.

Completed forms and any additional documentation should be mailed or faxed to the address or fax number shown on the claim form.

Questions regarding procedures or proper use of forms and claim status should be directed to the Dearborn National Claim Customer Service department at **1-800-778-2281**.

When competing any of the claim forms, please follow the instructions carefully.

SUBMITTING A DEATH CLAIM

The following documents must accompany the claim submission:

1. A certified death certificate with a seal for total coverages of more than $25,000. If coverage is $25,000 or less and the death occurred in the United States, a copy of the certified death certificate will be accepted, and
2. The insured's original beneficiary designation form, as well as any changes made subsequently.
3. For voluntary coverage, proof of enrollment and payroll deduction are required as applicable.

See sample on page 4. (Note: Only sections of the actual form are displayed here.)

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 778-2281
Fax: (312) 540-4706

Death Claim Form

Return to Dearborn National at:
Attention: Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

INSTRUCTIONS

The employer/administrator must complete the claim form as indicated and send attachments mentioned below. We will advise you if further documentation is necessary to complete the claim process.

Please submit the following documentation:

1. Death Claim Form:
   - Part 1 – Completed by the Employer/Administrator
   - Part 2 - Completed by the Beneficiary(ies)
2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.
3. A certified copy of the official death certificate.
4. If the benefits are based on salary, payroll records verifying the insured's annual earnings at the time of death.
5. If any portion of coverage is paid for by the insured, proof of payroll deduction.
6. For accidental death benefits, provide the following:
   a. Official completed police report
   b. Proof of seatbelt/airbag use if applicable
   c. Newspaper clipping(s) of accident, if applicable
   d. Coroner's report, findings and/or toxicology report
7. If the Beneficiary is:
   a. A minor, an estate or incompetent to handle financial matters: provide an original court order appointing a legal representative or guardian to handle the financial affairs of the minor, the estate, or the incompetent.
   b. Deceased: provide proof of death, a copy of the final certified death certificate, and documentation

   of the secondary beneficiary.

   c. A trust: provide documentation verifying existence of the trust, documentation that the trust has

   been named the beneficiary, and the tax identification number of the trust.
8. Each beneficiary must complete and sign the Beneficiary/Claimant Statement.

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Dearborn National

DEATH CLAIM FORM

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Phone Number: (800) 778-2281
Fax: (312) 540-4706

Death Claim Form

Return to Dearborn National at:
Attention: Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

Part 1 - To be completed by Employer/Administrator
Statement of Employer Employer/Plan Information

Group Name ____________ Subsidiary Name ____________

Group Number ____________ Account#/Division ____________

Address: ____________ Street ____________ City ____________ State ____________ Zip

Name and Title of Authorized Representative ____________

Phone Number ____________ Fax Number ____________

E-Mail Address ____________

Preferred communication: ☐E-mail ☐Phone ☐Fax

Deceased Person Information (include Certified Copy of Death Certificate)

Name ____________ Last ____________ First ____________ Middle ____________ Relation to Employee/Member ____________ Date of Death

Insured Person Information

Name of Claimant ____________ Last ____________ First ____________ Middle

Social Security No.____________ Class ____________ Date of Birth ____________ Hire Date ____________

Occupation ____________ Insurance Effective Date ____________ Annual Salary ____________

Date of Last Salary Increase ____________ Work Schedule _____ hrs/wk

(If salary based benefit or if any portion of premium is contributory please submit proof of payroll deduction)

Last Day Worked ____________ Reason for cessation of work ____________

Date of Last Premium Contribution: Group ____________ Member ____________

(resignation, disability, retirement, illness, layoff, leave of absence, vacation, other - please list)

If Retired, Date of Retirement ____________ If Terminated Date of Termination ____________ If Disabled, Date of Disability ____________

Waiver of Premium: ☐Yes ☐No Continuation of Life Insurance: ☐Yes ☐No Extended Life: ☐Yes ☐No

Beneficiary(ies) (include address and phone #) ____________

Online Beneficiary Tracking: ☐Yes ☐No Tracking System ____________

Amount of Insurance: Basic Life ____________ Additional Benefits Seat Belt ____________

Supplemental Life ____________ Air Bag ____________

AD&D ____________ Critical Illness ____________

Voluntary Life ____________ Education ____________

Dependent Life ____________ Other ____________

If Deceased is a Dependent Child, Please Complete the Following:

Dependent Child's Date of Birth ____________ Full-Time Student: ☐Yes ☐No School ____________

Is He/She Incapacitated and Reliant on the Employee for Financial Support: ☐Yes ☐No

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative ____________

Print Name ____________ Date ____________

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Underwritten by Dearborn National® Life Insurance Company

Phone Number: (800) 778-2281
Fax: (312) 540-4706

Death Claim Form

Return to Dearborn National at:
Attention: Claims Department
1020 31st Street
Downers Grove, IL 60515-5591

Part 2 - To be completed by Beneficiary
***If there is more than one beneficiary, each must completed a separate form.See Instructions page if beneficiary is a minor**

Name: ______________________ ______________________ __________
Last First Middle

Maiden Name ______________________ Alias Name ______________________

Date of Birth ______________________ Social Security No. ______________________

Address: ______________________ ______________ ________ ________
Street City State Zip

Phone ______________ E-Mail ______________________

Relationship to Deceased ______________ Comments ______________

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Beneficiary ______________________

Print Name ______________________ Date ______________

IRS Certification

Are you a U.S. Citizen: ☐Yes ☐No

(If No - IRS Form W-8 required) Provide other work ID if available ______________________

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. If you fail to certify, we may be required to withhold federal and state tax.

Your Signature ______________________

Print Name ______________________ Date ______________

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SHORT-TERM DISABILITY (STD) CLAIM

Forms should be completed by submitting a STD claim after the employee's last day worked. Completed forms should be faxed or mailed to Dearborn National at the address shown on the claim form.

Please Note: If you have Voluntary STD coverage with Dearborn National, please submit the most current enrollment form your employee has completed, as well as any recent change forms that have been completed during past annual enrollment periods.

See sample on page 7 as a guide to completing this form. (Note: Only sections of the actual form are displayed here.)

LONG-TERM DISABILITY (LTD) CLAIM

If your company has an STD plan with Dearborn National and the STD claim form has already been completed and submitted to Dearborn National, the claimant may not be required to submit a LTD claim form. Dearborn National will contact the claimant if additional information is required.

If your company does not have an STD plan with Dearborn National, the LTD claim form should be submitted approximately 6 to 8 weeks prior to the end of the elimination period. Completed claim forms should be faxed or mailed to Dearborn National at the address shown on the claim form.

See samples on page 7 (STD) and page 10 (LTD). (Note: Only sections of the actual form are displayed here.)

Dearborn National®

STD CLAIM FORM

Underwritten by Dearborn National® Life Insurance Company
Phone Number: (877) 348-0487
Fax: (877) 404-6457

Group Short-Term Disability Claim Form

Return to Dearborn National at:
Attention: Claim Department
P.O. Box 7071
Downers Grove, IL 60515

NOTE: All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

NOTICE OF CLAIM - Employer Instructions

Complete the following when an employee will be out of work longer than the STD elimination period:

A. Complete the Employer's Report of Claim in full;

B. Give claim form to claimant for completion; and

C. Request copy of awards from other sources of benefits: Social Security, Workers' Compensation, retirement, state disability, and others.

When claimant returns the form to you:

A. Attach:

- Job description (detailed duties)
- Proof of enrollment (only for contributory coverage)
- Documentation of earnings if other than straight salary
- If Workers' Compensation claim filed, include copy of First Report of Accident and the decision

B. Return, together with all attachments, to Dearborn National® Life Insurance Company (Dearborn National) at the address shown above.

APPLICATION FOR STD BENEFITS - Employee Instructions

A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Dearborn National or its representative to secure additional information if necessary to make a decision on your claim.

B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

A. Attach a copy of Social Security and other income entitlement awards; and

B. Return to your employer.

Electronic Funds Transfer (EFT) Authorization

If you are eligible for weekly benefits, and wish to receive benefits via direct deposit, complete the attached form and return as indicated.

APPLICATION FOR STD BENEFITS - Physician Instructions

As soon as the claimant gives you this form:

A. Complete the APS on page 4 of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.

B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

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. (Not enforceable in Oregon or Virginia.)

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Underwritten by Dearborn National® Life Insurance Company
Phone Number: (877) 348-0487
Fax: (877) 404-6457

Group Short-Term Disability Claim Form

Return to Dearborn National at:
Attention: Claim Department
P.O. Box 7071
Downers Grove, IL 60515

GROUP NUMBER ____________________

PLEASE ✓ TYPE OF CLAIM BEING SUBMITTED

☐ Short-Term Disability
☐ Voluntary STD
☐ Specific Disease Benefit

CLAIMANT STATEMENT (Please Print)

Claimant Name (Last)	(First)	(MI)	Social Security #	Height	Weight	Birth Date
Address	City		State	Zip	Phone Number	
E-mail						
Name of Employer	Occupation			Maiden Name	Alias Name	

Are you filing a claim for this disability under the Workers' Compensation Act: ☐ Yes ☐ No
Are you filing a claim for this disability under the Social Security Act: ☐ Yes ☐ No

Describe other income you are receiving:

YES	NO	TYPE *	AMOUNT	DATE BENEFITS BEGAN	DATE BENEFITS TERMINATED	NAME OF INSURANCE CARRIER
☐	☐	Social Security (disability or retirement)	$			
☐	☐	State disability	$			
☐	☐	Retirement (normal, early or disability)	$			
☐	☐	Workers' Compensation	$			
☐	☐	Group disability benefits	$			
☐	☐	Other (describe)	$			

** Please send a copy of your award letter, if applicable.*

1. Date of accident or beginning of sickness ____________ Date last worked ____________
2. Nature of injury or illness ____________
3. If injury, describe how, when and where occurred ____________
4. Have you ever had same or similar illness: ☐ Yes ☐ No If yes, give dates: From ____________ To ____________
5. Name of hospital(s) ____________ Dates confined: From ____________ To ____________
   Address of hospital(s) ____________
6. Name and address of Doctor(s) ____________
   Dates of treatment ____________
7. Between what dates were you unable to perform any duties From ______ To ______ From ______ To ______

AGREEMENTS AND AUTHORIZATION: I authorize my employer to disclose all information necessary to process my claim to Dearborn National® Life Insurance Company (Dearborn National).
I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn National's claim department or its authorized representative(s) information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize Dearborn National to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.
This authorization shall expire on the date that I receive notice of Dearborn National's final decision on my claim. I understand and agree that:
- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records.;
- A photocopy of this authorization shall be as valid as the original;

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from Dearborn National.
If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, Dearborn National has the right to deny my claim.
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. (Not enforceable in Oregon or Virginia.)

Signature of Employee ____________________ Date ____________

Underwritten by Dearborn National® Life Insurance Company
Phone Number: (877) 348-0487
Fax: (877) 404-6457

Group Short-Term Disability Claim Form

Return to Dearborn National at:
Attention: Claim Department
P.O. Box 7071
Downers Grove, IL 60515

EMPLOYER STATEMENT

Employee Name (Last)	(First)	(MI)	Social Security #	Date of Hire	Effective Date of Insurance
Employer Name					Employer Group Number
Employer Address	City		State	Zip	Phone Number
Employer E-mail Address					
Last Day Worked ☐ FT ☐ PT	Date Returned ☐ FT ☐ PT	Base Salary ☐ Hourly ☐ Monthly ☐ Weekly		Class	Hours worked per week
Workers' Comp Claim Filed for this Disability: ☐ Yes ☐ No	SELF ADMINISTERED ONLY: Amount of weekly disability benefit $ ______		Claimant received: Salary continuation through ______ Vacation through ______ Sick Pay through ______		
Employee Occupation					

Does the Employee contribute towards the cost of this STD insurance: ☐ yes ☐ no If "Yes,": ☐ Pre-Tax ☐ Post-Tax
If "Post-tax," ______ % premium dollars paid by employer, ______ % paid by claimant.
See IRS Publication *15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting* and/or *IRS Revenue Ruling 2004-55* for more information on calculating the taxable percentage.

Signature	Title	Date	Telephone

ATTENDING PHYSICIAN STATEMENT

(Must be completed in full at the patient's expense)

Claimant's Name (Last)	(First)	(MI)	☐ Male ☐ Female	Date	Age
Address	City	State	Zip		

1. Nature and origin of ☐ sickness ☐ injury Diagnosis (describe complications, if any) ______
2. Date symptoms first appeared or date of accident ______ Date patient first consulted you for this condition ______
3. Is the condition work related ☐ yes ☐ no ______
4. Describe any other disease or complications effecting present condition ______
5. Date and surgical procedure(s), if any ______
6. If maternity give estimated or actual date of delivery ______ ☐ Vaginal ☐ C-section
7. Please give dates of treatment other than surgical ______
8. Please give hospital name & address with dates of confinement From ______ To ______ ☐ Inpatient ☐ Outpatient
   Hospital name ______ Hospital address ______
9. Has patient ever had same or similar condition ☐ yes ☐ no (If yes, state when and describe)
10. Is patient still under your care ☐ yes ☐ no (If discharged give date and degree of recovery)
11. Is patient under the care of another physician ☐ yes ☐ no (If yes, provide name, address and phone # of physician)
12. Patient was or will be continuously disabled (unable to work)
    In his/her own occupation From ______ To ______ In his/her own occupation From ______ To ______
    Patient can return to work ☐ Full time ☐ Part time On ______ Restrictions ______
13. Patient was or will be partially disabled ______ From ______ Through ______
14. In your opinion, is patient candidate for rehabilitation ☐ To return to own occupation ☐ For another occupation ☐ no
15. If patient is diagnosed as terminal, is life expecatncy ☐ 6 months or less ☐ 12 months or less ☐ Other ______

Remarks ______

Physician Name ______ Phone ______ Fax ______
Physician Signature ______ Date ______
Address ______ City ______ State ______ Zip ______
Specialty: ☐ FP ☐ IM ☐ PM&R ☐ Neuro ☐ Ortho ☐ OBG ☐ Psych ☐ Other ______

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LTD CLAIM FORM

Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Employer Report Of Claim

To be Completed by Employer

CLAIMANT

1. Employee Name (Last) ____ (First) ____ (M.I.) ____
2. Social Security No. ____
3. Date of Birth ____
4. Address ____ City ____ State ____ Zip Code ____

EMPLOYMENT

5. Insurance Class ____
6. Employee Date of Hire ____
7. Date Employee Became Insured for LTD ____
8. Date Employee was actually last present at work ____
9. Occupation at Time Last Worked (attach job description) ____
10. Work Schedule at Time Last Worked — No. of Days Per Week ____ No. of Days Per Day ____
11. Reason for stopping: Date ____
    ☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Resigned
    ☐ Retired ☐ Dismissed ☐ Other ☐ Vacation
12. Has Employee Returned to Work: ☐ Yes ☐ No
    If Yes: ☐ Part-Time ☐ Full-Time
    Date ____ Date ____

INCOME

13. How is Employee Paid:
    ☐ Straight Salary ☐ Hourly ☐ Commissions Only
    ☐ Salary & Commission ☐ Salary & Bonus
14. Employee's Basic Monthly Earnings $ ____ LTD Benefit ____

Does the Employee contribute towards the cost of this LTD insurance: ☐ yes ☐ no If "Yes,": ☐ Pre-Tax ☐ Post-Tax
If "Post-tax," ____ % premium dollars paid by employer, ____ % paid by claimant.
See IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for more information on calculating the taxable percentage.

OTHER BENEFITS

16. Has the Insured Received Other Disability Payments Since Time Last Worked
    Salary Continuance: ☐ Yes Wkly. Amt. $ ____ Date Benefits Cease ____ ☐ No
    Insured Short Term Disability: ☐ Yes Wkly. Amt. $ ____ Date Benefits Cease ____ ☐ No
    Salary Continuance: ☐ Yes Wkly. Amt. $ ____ Date Benefits Cease ____ ☐ No
17. Did Claim Result From Job Activity: ☐ Yes Explain ____ ☐ No
18. Has Workers' Compensation claim been filed:
    ☐ Yes (Enclose copy of 1st report of accident
    ☐ No
    ☐ Pending
    ☐ Denied (Enclose copy of denial)
19. Workers' Comp. Weekly Amount: $ ____

RETIREMENT

20. Is Employee Covered by Employer Sponsored Retirement Plan: ☐ Yes ☐ No
21. Does Retirement Plan Contain a Disability Provision: ☐ Yes ☐ No
22. Is Employee or will Employee be Eligible for a Disability or Retirement Pension:
    ☐ Yes If Yes: ☐ Disability ☐ Retirement ☐ Other ____
    ☐ No
    Monthly Amt. $ ____
    Commence Date of Benefits ____
    (Please Enclose Copy of Summary Plan Description)

NOTE: If any Portion of this Pension Benefit is Attributable to the Employee's Contribution, Please Provide Details Including the Percentage of His/Her Contribution to the Total Contribution.

CERTIFICATION

23. Employer Name (association and policyholder, if other) ____
24. Telephone No. ____
25. Group Policy No. ____
26. Address ____ City ____ State ____ Zip Code ____
27. Employer (Taxpayer) I.D. Number (EIN) ____
    OR
28. Public Employer Social Security No. 69 ____
29. Name of Person Completing this Form (Printed) ____
30. Signature of Authorized Insurance Representative ____ Title ____ Date ____

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Underwritten by Dearborn National® Life Insurance Company

Employee Claim Statement

To be Completed by Employee

CLAIMANT

1. Full Name (Last) (First) (M.I.) | 2. Maiden Name | 3. Alias Name | 4. Social Security No.

5. Phone Number | 6. Date of Birth | 7. Height ___ - ___ ft. in. | 8. Weight ___ lbs. | 9. Sex ☐ Male ☐ Female | 10. Address

City | State | Zip Code | 11. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | 12. Spouse's Date of Birth ___ First Name ___ | 13. Is Spouse Employed ☐ Yes ☐ No

14. Number of Children (Under age 19) | 15. List Names and DOB of unmarried children in high school

EMPLOYMENT

16. Employer Name | 17. Group Policy No.

18. Occupation (List the duties of your occupation at the time of disability)

19. Accident or first noticed symptoms of illness on | 20. I have been unable to work due to the disability since | 21. I returned to work on a part-time basis on | 22. I returned to work on a full-time basis on

23. Is Your Accident or Illness Related to Your Occupation: ☐ Yes ☐ No Explain ___ | 24. Have You or do You Intend to File a Workers' Comp Claim: ☐ Yes ☐ No

CLAIM HISTORY

25. Describe How and Where the Accident Occurred or Describe the Onset and Nature of Your Illness

26. Date You Were First Treated for Illness/Injury

27. Treated By

	Name	Street Address	City	State	Zip
Hospital					
Doctor					

28. Have You had the Same or Similar Condition Before

29. Treated By

	Name	Street Address	City	State	Zip
Hospital					
Doctor					

OTHER INCOME

30. Describe Other Income You are Receiving

			Amount	Date Began	Term.
☐ Yes	☐ No	Social Security (disability or retirement)	$		
☐ Yes	☐ No	State Disability	$		
☐ Yes	☐ No	Retirement (normal, early, or disability)	$		
☐ Yes	☐ No	Workers' Compensation	$		
☐ Yes	☐ No	Group Disability Benefits	$		
☐ Yes	☐ No	Other (describe) ___	$		

31. Have You Applied, or do You Plan to Apply for Benefits Described Above: ☐ Yes ☐ No
Type ___ Date Application Filed ___
Type ___ Date Application Filed ___

32. If Your Request for Benefits is Approved, do You want Us to Withhold Amounts from each Benefit for Federal Income Tax Purposes: ☐ Yes ☐ No If Yes, Please Complete and Attach IRS Form W4S.

AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Dearborn National® Life Insurance Company's (Dearborn National) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim.
This authorization expires on the date I receive notice of Dearborn National's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by Dearborn National prior to receipt of the revocation. Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from Dearborn National. **If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization,** Dearborn National **has the right to deny my claim.**

Signature of Employee ___ Date ___

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

Dearborn National®

LTD CLAIM FORM

Underwritten by Dearborn National® Life Insurance Company

Attending Physician Statement

Name of Patient (Last) (First) (M.I.) | Date of Birth | *Please submit bill for records with this claim.

HISTORY

(a) When did symptoms first appear or accident happen
(b) Date patient ceased work because of disability
(c) Has patient ever had same or similar condition ☐ Yes ☐ No If Yes, state when and describe
(d) Is condition due to injury or sickness arising out of patient's employment ☐ Yes ☐ No ☐ Unknown
(e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (including complications) Please submit all office notes regarding this condition*
(b) Subjective symptoms
(c) Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

TREATMENT

(a) Date of first visit
(b) Date of last visit
(c) Frequency ☐ Monthly ☐ Weekly ☐ Other ______
(d) Nature of treatment (including surgery and medications prescribed, if any)

PROGRESS

(a) Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
(b) Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital confined
(c) Has patient been hospital confined ☐ Yes ☐ No Confined from ______ through ______
If, yes, give hospital name and address ______

CARDIAC

(a) Functional capacity (American Heart Ass'n.)
☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)
(b) Blood Pressure (last visit) ______ systolic/diastolic

IMPAIRMENT

(a) Physical impairments (*as defined in 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 ______

(b) Mental Impairments (if applicable)
(a) Please define "stress" as it applies to this claimant
(b) What stress and problems in 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 psychological, physiological, personal and social adjustment (severe limitations)
Remarks ______

PROGNOSIS

(a) Is patient now totally disabled Patient's job: ☐ Yes ☐ No Any other work: ☐ Yes ☐ No
(b) Date patient became disabled due to present illness
(c) When do you expect a fundamental or marked change in the future:
☐ 1 Mo ☐ 1-3 Mo ☐ 3-6 Mo ☐ Never Applies To: ☐ Patient's job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation Patient's job: ☐ Yes ☐ No Any other work: ☐ Yes ☐ No
(b) Can present job be modified to allow for handling with impairment: ☐ Yes ☐ No
(c) When could trial employment commence Date ______ Patient's job: ☐ Full-time ☐ Part-time Date ______ Patient's job: ☐ Full-time ☐ Part-time

REMARKS

(Limitations, Therapy, etc.)

Name (Attending Physician) (Last) | (First) | Degree | Telephone ______ Fax# ______

Address | City | State | Zip

Signature | Date

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TAX REPORTING GUIDELINES

Internal Revenue Service (IRS) Publication 15-A requires Dearborn National to report to employers the benefits paid and taxes withheld for their employees.

As a policyholder, you are responsible for matching the employee's portion of social security and medicare taxes (FICA) on all taxable STD and LTD benefits as well as associated W-2 reporting. Paid claims reports will be sent weekly, quarterly and annually.

TAXABILITY OF DISABILITY BENEFITS

STD and LTD benefits may be considered taxable income. The taxability of these benefits is determined by who pays the premium and how premium is paid.

If the employee pays any portion of the premium on a post-tax basis, the portion of their benefit attributable to their percentage of premium contribution is not taxable. If any portion of the premium is paid by the employee on a pre-tax basis, the portion of their benefit attributable to their percentage of premium contribution is taxable. Any portion of their benefit attributable to their employer's contribution is taxable.

If the benefit is taxable, Dearborn National is required to withhold social security and medicare taxes (FICA); however, federal income tax (FIT) is not required to be withheld. Dearborn National will withhold FIT by request.

IRS Form W4-S should be submitted with the claim form to Dearborn National if FIT withholding is requested by your employee.

YEAR-END TAX REPORTING

For those employers whose group insurance plan includes STD or LTD insurance, Dearborn National can also prepare and issue a W-2 for each insured receiving disability payments. Groups must be fully insured. A signed W-2 agreement is required. Please refer to the agreement (found on our website) for specific time limits that must be met.

Paid Disability Claims
FICA/FIT Withholding Report for: 1/1/2008-3/31/2008

Policyholder: **SAMPLE GROUP** Policy #: **GFZ00001/1**
Division #: 1 Dept: 1

SAMPLE GROUP

Claim #	LOB	Check #	Benefit Period	Pay Type	Pay Date	Payee	Pmt Amt	SS	Med	Fed	State	Other	Check Amt
	Claimant:	SUSAN JOHNSON				SSN:	111223333						
200825999	REGULAR LTD	10437576 8	12/08/07 -01/08/08	CHECK	1/22/08	SUSAN JOHNSON	1265.72	78.47	18.35	0.00	0.00	0.00	1168.90
200825999	REGULAR LTD	10443947 9	01/05/08 -02/02/08	CHECK	2/11/08	SUSAN JOHNSON	1363.08	84.51	23.72	0.00	0.00	0.00	1254.85
200825999	REGULAR LTD	1045315710	02/02/08 -03/01/08	CHECK	3/6/08	SUSAN JOHNSON	1363.08	84.51	19.76	200.00	0.00	0.00	1058.81
						Certificate Holder Totals:	3991.88	247.49	61.83	200.00	0.00	0.00	3482.56
	Claimant:	DANIEL SMITH				SSN:	222334444						
200825998	REGULAR STD	10434107 4	12/03/07 -12/24/07	CHECK	1/11/08	DANIEL SMITH	1269.39	78.70	18.41	0.00	0.00	0.00	1172.28
						Certificate Holder Totals:	1269.39	78.70	18.41	0.00	0.00	0.00	1172.28
	Claimant:	AMY WRIGHT				SSN:	333445555						
200825997	REGULAR STD	10441657 3	12/12/07 -02/06/08	CHECK	2/1/08	AMY WRIGHT	2928.00	181.54	42.46	0.00	0.00	0.00	2704.00
200825997	REGULAR STD	10446195 4	02/06/08 -02/20/08	CHECK	2/15/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
200825997	REGULAR STD	10451693 5	02/20/08 -03/05/08	CHECK	3/3/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
200825997	REGULAR STD	10455658 6	03/05/08 -03/19/08	CHECK	3/14/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
200825997	REGULAR STD	10461433 7	03/19/08 -04/02/08	CHECK	3/31/08	AMY WRIGHT	732.00	45.38	10.61	0.00	0.00	0.00	676.01
						Certificate Holder Totals:	5856.00	363.06	84.90	0.00	0.00	0.00	5408.04
						Group Totals:	11,117.27	689.25	165.14	200.00	0.00	0.00	10,062.88

Dearborn National®

www.dearbornnational.com

Partnership. Solutions. Strength.

BENEFICIARY RESOURCE SERVICES™

A WELLNESS PLAN FOR LIFE

When a loved one dies, families often face complex issues ranging from estate planning, legal questions, funeral planning, coping with grief and financial uncertainties. That's why Dearborn National offers Beneficiary Resource Services, a program that combines family wellness and security at the most difficult of times. Services include grief and financial counseling, funeral planning, legal support, as well as online will preparation. Beneficiary Resource Services is provided by Bensinger, DuPont & Associates (BDA).

SERVICES FOR BENEFICIARIES AND THEIR FAMILIES

The following services are available after a death claim or for those that qualify for an accelerated death benefit:

Unlimited Phone Contact
Available for up to one year with a grief counselor, legal advisor or financial planner.

Face-to-Face Working Sessions*
Five face-to-face working sessions are available to you or your beneficiaries. All five sessions may be used with one grief counselor or legal advisor or they may be split among the two types of counselors or advisors in geographically accessible locations. A one-hour financial consultation on the phone is also available.

Referrals and Support Services
BDA maintains a comprehensive directory of qualified and accessible grief counselors and legal and financial consultants.

Follow Up
Counselors will initiate follow-up calls when necessary for up to one full year from the date of initial contact.

BDA's nationwide network of experienced professionals can offer counseling for those facing difficult emotional, financial or legal issues. BDA's counselors are available 24 hours a day, 365 days a year. All calls are completely confidential.

BENEFICIARY RESOURCE SERVICES

Counseling:

(800) 769-9187

www.beneficiaryresource.com
Username: Dearborn National

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SERVICES FOR INSUREDS AND THEIR FAMILIES

Online Will Preparation

A will is one of the most important documents every adult should have, and creating one has never been easier. You and your family have access to a full legal library with many estate planning documents, including an online will. You can create your own will online in a safe and secure way, right from your home. The will can be saved and updated as family situations change. Creating a will provides security and peace of mind for several reasons:

- Appoints a guardian for children
- Controls where property and assets go
- Provides family security
- Without one, the state can make these decisions

Create your will by visiting www.beneficiaryresource.com and entering the username: Dearborn National.

TO ACCESS THESE VALUABLE RESOURCES, VISIT

www.beneficiaryresource.com

Username: Dearborn National

ONLINE FUNERAL PLANNING

You have access to an online funeral planning site that features a variety of helpful tools and information, such as:

- A downloadable funeral planning guide to document vital information your loved ones will need when making final arrangements
- Calculators to estimate and compare expenses for various types of funeral arrangements
- Information on funeral requirements and various religious customs
- Directories to locate funeral homes and cemeteries in the your area

Access the Online Funeral Planning site by visiting www.beneficiaryresource.com and entering the username: Dearborn National.

For employee distribution.

**May include face-to-face sessions, over-the-phone sessions or time taken for research or document preparation.*

Beneficiary Resource Services is provided by Bensinger, DuPont & Associates. Dearborn National® Life Insurance Company does not provide or insure any part of Beneficiary Resource Services. Legal services will not be provided for court proceedings or for the preparation of briefs for legal appearances or actions or for any action against any party providing Beneficiary Resource Services. Legal services provided under Beneficiary Resource Services are not intended for adversarial matters. Neither BDA nor Dearborn National® Life Insurance Company is responsible or liable for care or advice rendered by any referral resources.

This brochure is for illustrative purposes only and is not a contract. It is intended to provide a general overview of the services described. Only the service agreement can provide the actual terms, coverages, services, amounts and conditions. Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company, (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the U. S. Virgin Islands and Puerto Rico. Product features and availability vary by state.

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A14-0016-0514 (09/16)