

Regence

Life and Health Insurance Company

P.O. Box 1271, MS E-3A
 Portland, Oregon 97207-1271
 (800) 794-5390 ♦ (503) 721-7161

APPLICATION FOR EXTENDED LIFE INSURANCE COVERAGE

By furnishing this claim form and investigating the claim the company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

Part I TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

Group Policy Number

Social Security Number

1. Name of insured	Last	First	Initial	Insurance Class	Amount of Insurance: Basic \$ _____ Voluntary \$ _____				
2. Address (No. & Street, City, State, Zip Code)				Telephone No.	Date of Birth	Month	Day	Year	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>

3. Date on which total disability began	Month	Day	Year	Cause of disability			
4. Do you expect insured to return to work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If "Yes", give approximate date		Month	Day	Year

5. Date Employed	Month	Day	Year	Job Title (for life insurance schedule)
6. Date insurance became effective	Month	Day	Year	Job Description and Duties

7. Date on which the insured last worked full time / part time (Circle One)				Month	Day	Year				
8. Has this employee or member's insurance been terminated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If "Yes"; Date of termination:	Month	Day	Year	Reason	Has this employee or member's life insurance been converted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

9. PLEASE ANSWER IF ISSUED TO A UNION OR TRUSTEE PLAN

a. Date on which the insured became a member _____

b. Date on which the insured terminated membership _____

c. Was the insured eligible for Life Insurance coverage on the date disability began? Yes No

TO WHOM DO YOU WISH US TO DIRECT ALL CORRESPONDENCE ON THIS CLAIM?	Company Name	To the attention of	Title
	Telephone No.	Address (No. & Street)	(City) (State) (Zip Code)

Date	Name of Group Policyholder	By	Title	Telephone No.
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Part II**TO BE COMPLETED BY EMPLOYEE OR MEMBER**

All questions on this form should be fully answered by the insured if competent to do so. If not, and if no guardian has been appointed, the form may be completed by the beneficiary or a close relative. If a guardian has been appointed, the form should be completed by the guardian and a certified copy of letters of guardianship forwarded. By furnishing this form, the company shall not be held to admit the validity of any claim or waive the breach of any condition of the policy.

1. a. Full Name	Group Number
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b. Address (No. & Street, City, State, Zip Code)	Social Security Number
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c. Telephone No.	Date of Birth:	Month	Day	Year
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d. Job title at the time of your disability

e. Your employer at the time of your disability

2. Describe the duties of your usual job in your own words:

3a. List any skills which you may have as a result of prior employment, training or education, or military service:

3b. List last year of school completed (e.g., 6th Grade, 12th Grade, College Degree, etc.):

4. Date when your health first began to be affected	Date on which you last worked full time / part time (Circle One)
Month Day Year	Month Day Year

5. Describe fully the nature of your disability, its cause and how it prevents you from working:

6. Please indicate if condition is due to an injury	Date of injury	Where did injury occur?
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7. Describe how injury occurred

8a. Are you now totally disabled and unable to work?	8b. State briefly your present daily activities
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9. Are you now gainfully employed in any occupation?

Yes No

If yes, indicate the date you commenced such duties.

Month Day Year

10. On what date do you expect to be able to return to work?

Month Day Year

11. List the physicians you have consulted during your present disability: (Attach a separate piece of paper if additional space is needed)

Name	Address	Telephone No.	From	Date	To
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

12. Are you entitled to disability benefits from any of these sources because of this disability:

Sources	Identify Insurance or Agency	Benefit Amount	How Payable (Lump, Mthly, Wkly, etc.)	
			From	Thru
Workers' Compensation	_____	_____	_____	_____
Social Security Administration (include copy of award)	_____	_____	_____	_____
Health or Welfare Plan (e.g., Long Term Disability)	_____	_____	_____	_____
Retirement or Pension Plan	_____	_____	_____	_____
State, Provincial or Federal Agency	_____	_____	_____	_____
Other	_____	_____	_____	_____

INSURANCE FRAUD WARNING -- Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company, medical prepayment plan, service organization, physician, practitioner or any other person, any hospital, including the Veterans Administration, or other institution to release to or obtain from Regence Life and Health Insurance Company any medical or benefit payment information that may be required to establish the validity of this claim, and further authorize said company, person or organization, to disclose any personal or claim information required for medical case study or review. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for two years from date shown.

EMPLOYEE SIGNATURE



DATE

YOU MUST NOTIFY REGENCE LIFE AND HEALTH INSURANCE COMPANY PROMPTLY IF:

- a. Your medical condition improves so that you would be able to work, even though you have not yet returned to work.
- b. You go to work whether as an employee or as a self-employed person.

ATTENDING PHYSICIAN'S STATEMENT

The purpose of this report is to assist us in making a continuing disability determination. In filing this report, please include sufficient details of history, physical or diagnostic findings, clinical course, therapy and response to enable us to make this determination. After signing the form, return it to Regence Life and Health Insurance Company, PO Box 1271, MS E-3A, Portland, Oregon 97207-1271, or fax this form to (503) 225-4819. **THE PATIENT IS RESPONSIBLE FOR ANY EXPENSE INVOLVED IN THE COMPLETION OF THIS FORM.**

1. PATIENT'S NAME _____		SOCIAL SECURITY NUMBER _____	
DIAGNOSIS (Subjective Symptoms & Objective Findings) _____			
DATE PATIENT CEASED WORKING BECAUSE OF DISABILITY _____			
2. PHYSICAL IMPAIRMENT		MENTAL IMPAIRMENT (if applicable). Please define "stress" as it applies to this patient.	
<input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0 - 10%) <input type="checkbox"/> Class 2 - Slight limitation of functional capacity; capable of light manual activity. (15 - 30%) <input type="checkbox"/> Class 3 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35 - 55%) <input type="checkbox"/> Class 4 - Marked limitation. (60 - 70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75 - 100%)		<input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)	
3. CARDIAC			
(a) Functional capacity..... <input type="checkbox"/> Class 1 (No limitation)		<input type="checkbox"/> Class 2 (Slight limitation)	
(a) (American Heart Association) <input type="checkbox"/> Class 3 (Marked limitation)		<input type="checkbox"/> Class 4 (Complete limitation)	
(b) Blood Pressure /			
systolic		diastolic	
4. DATES OF TREATMENT			
(a) Date of first visit.....		Mo. _____	Day _____ 20 _____
(b) Date of last visit.....		Mo. _____	Day _____ 20 _____
(c) Frequency of visits.....		Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/> Other (Specify) <input type="checkbox"/> _____
(d) Is patient still under your care for this condition?.....		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "No", give date and reason your services terminated.....		Mo. _____	Day _____ 20 _____
5. NATURE OF TREATMENT (including Surgery, if any) _____			
6. PROGRESS			
(a) Check one..... <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed			
(b) Is patient..... <input type="checkbox"/> Ambulatory? <input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?			
(c) If hospital confined , give details under " COMMENTS " section below.			
7. Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes <input type="checkbox"/> No <input type="checkbox"/>			
8. PROGNOSIS			
(a) Do you expect a fundamental or marked change in the future? Improvement Yes <input type="checkbox"/> No <input type="checkbox"/> / Deterioration Yes <input type="checkbox"/> No <input type="checkbox"/>			
(b) Will patient recover sufficiently to perform duties of:			
		HIS/HER JOB	Yes <input type="checkbox"/> No <input type="checkbox"/> Immediately <input type="checkbox"/> 3 - 6 mos <input type="checkbox"/> 6 - 12 mos <input type="checkbox"/> Over 1 yr. <input type="checkbox"/>
		OTHER WORK	Yes <input type="checkbox"/> No <input type="checkbox"/> Immediately <input type="checkbox"/> 3 - 6 mos <input type="checkbox"/> 6 - 12 mos <input type="checkbox"/> Over 1 yr. <input type="checkbox"/>
(c) Comments _____			
9. REHABILITATION			
(a) Is patient a suitable candidate for trial employment or job training?		HIS/HER JOB	OTHER WORK
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If yes, when could he/she commence trial employment?		Mo. _____	Day _____ Yr. _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/>
(c) If yes, please explain type and extent of work _____			
10. COMMENTS (i.e., additional studies, consultations, vocational training, etc.) _____			
Print Attending Physician Name		Degree	Telephone No. Fax
Street Address		City or Town	State or Province Zip Code
Physician's Signature		Date	