



Disability Claim Report for Extended Life and Medical Benefits and Accidental Dismemberment Benefits

GE Financial
Employer Services Group

GE Group Life Assurance Company
PO Box 810, Greenfield, MA 01302-0810

Type(s) of Claim Check appropriate box(es) Waiver of Premium-Life Benefit Major Medical Request
For Dismemberment Benefit, check appropriate box(es) Loss of Limb Loss of Vision Loss of Hearing Loss of Speech
 Quadriplegia Paraplegia Hemiplegia

Employer's Statement

Name of Claimant (Last, First, M.I.) - Please Print			Aliases	Basic Annual Earnings at Time of Disability \$	Date of Last Salary Change / /
Insured Under Group Account Number	Effective Date of Full Time Employment		Effective Date of Employee's Insurance / /	Occupation	Date Last Worked / /
Amount of Employee's Insurance Basic \$	Supplemental \$	Voluntary \$	Has employee returned to work? (If "Yes" give date) <input type="checkbox"/> Yes <input type="checkbox"/> No	Have premiums ceased? (If "Yes", give Date) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for Leaving Work: <input type="checkbox"/> Retired <input type="checkbox"/> Absent on Sick Leave <input type="checkbox"/> Totally Disabled <input type="checkbox"/> Absent Because of Temporary Layoff <input type="checkbox"/> No Longer Employed					
Important Notice: Please provide us with a copy of the Employee's original Enrollment Card and any subsequent change of beneficiary or benefit election forms.					Union Member <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Employer				Telephone Number	
Address (No., Street, City, State, ZIP Code)				FAX Number	
Signature of Benefits Administrator			Title	Date Signed	

Employee's Statement

Date of Birth	Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Last Worked	Date You Expect to Be Able to Work
Address (No., Street, City, State, ZIP Code)				
Have you been approved for Social Security disability benefits? (If so, please attach a copy of the award letter for our review.) <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you filed a disability claim with another insurance carrier? (If so, please provide us with their name and address.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name and Address of Other Insurance Carrier				
If disability is due to an accident, how, when and where did it occur?				
Describe in detail how your disability has affected your daily activities.				
Number of Dependent Children - List name(s) and date(s) of birth				

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider, health care facility, the Medical Information Bureau or similar organization, insurance or reinsurance company, to disclose or furnish to **GE Group Life Assurance Company (GEGGLAC)** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. I further authorize any employer, group policyholder or benefits plan administrator to disclose or furnish my employment, financial and wage information to GEGGLAC and its legal representatives.

I authorize GEGGLAC to use or disclose this protected health information to any reinsurer and to any person or entity performing a business or legal function on behalf of GEGGLAC or as otherwise specifically permitted or required by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect a claim; (3) I have the right to revoke this authorization at any time by writing to GEGGLAC at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Telephone Number	Date Signed
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WARNING

STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT: 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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN FLORIDA: "Any person who knowingly and with intent to defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

IN NEW JERSEY: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

IN NEW YORK: "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 containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

Certificate of Attending Physician - To be furnished without expense to GE Group Life Assurance Company.

Name of Patient (Last, First, M.I.) - Please Print	Name of Attending Physician (PLEASE PRINT)	Telephone Number
Address (No., Street)	Address (No., Street)	
(City, State, ZIP Code)	(City, State, ZIP Code)	

Disability Claims

HISTORY	When did present illness begin or injury occur?		Referring Physician's Name	
	Is there a previous history of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referring Physician's Telephone Number	
DIAGNOSIS	Diagnosis		Is Insured Competent to Change His/Her Beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Symptoms		Please attach copies of any special reports or test results available	
TREATMENT	Date of First Visit	Date of Last Visit	Date Insured Was Obligated to Cease Work	Frequency of Visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other
PROGRESS	The patient is: <input type="checkbox"/> Recovered <input type="checkbox"/> Unimproved <input type="checkbox"/> Improved <input type="checkbox"/> Retrogressed		The patient is: <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital Confined	
PHYSICAL IMPAIRMENT	<input type="checkbox"/> Class 1 - No limitation of functional capacity, capable of heavy work*. No restrictions (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity*. (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity, capable of light work*. (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity, incapable of minimum (sedentary*) activity. (75-100%) *As defined in Federal Dictionary of Occupational Titles.			
MENTAL/NERVOUS IMPAIRMENT (if applicable)	<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, personal and social adjustment (severe limitations) <input type="checkbox"/> Is Patient competent to change his/her beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CARDIAC	Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 - No limitation <input type="checkbox"/> Class 2 - Slight limitation <input type="checkbox"/> Class 3 - Marked limitation <input type="checkbox"/> Class 4 - Complete limitation			
DEGREE OF DISABILITY	(a) Is patient unable to perform the duties of any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) What duties of patient's job is he/she incapable of performing?	
	(c) Do you expect an improvement in the future? (If "yes", when will patient recover sufficiently to perform any work duties?) <input type="checkbox"/> Yes <input type="checkbox"/> No			
REHABILITATION	Is patient a suitable candidate for future rehabilitation services? (i.e., Cardiopulmonary program, speech therapy, work-hardening, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Can present job be modified to allow for handling with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	When could trial employment commence? (Month/Day/Year) / / <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Would vocational counseling and/or retraining be recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Accidental Dismemberment Claims Only

Date of Loss	Was loss due to accidental means? <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Hearing - Is the patient totally deaf? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what was hearing at last observation?
Describe How Loss Occurred		Can hearing be improved by treatment, operation or hearing aid or device? <input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Limb - What was the anatomical level of amputation?		Loss of Speech - Has the patient suffered an entire loss of speech? <input type="checkbox"/> Yes <input type="checkbox"/> No Can speech be regained through treatment, operation or device? <input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Sight - Is the patient totally blind? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what was vision at last observation?		Paralysis - Is the loss of movement complete and permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No Can movement be regained through treatment or operation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can vision be improved by treatment, operation or lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has all practical use of vision been lost in the injured eye? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Remarks		
Attending Physician's Signature		Date Signed