

**Statement of Continuance of Life Insurance
Protection During Total Disability**

United HealthCare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-888-299-2070
Fax: 1-800-980-0298



Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

United HealthCare Insurance Company
Unimerica Insurance Company
Unimerica Life Insurance Company of New York

This section must be completed by the employee. If the employee is mentally incompetent, the section should be completed by the committee or guardian, or if none has been appointed, by the beneficiary named in the policy.

1. What is your full name? _____ Social Security # ____-____-____

2. What is your address, city, state, zip? _____ Phone #: _____
Cell #: _____

3. Give the following facts regarding yourself: Date of Birth: Mo _____ Day _____ Yr _____
Sex: Male Female Married Single Divorced

4. State the causes of your disability. _____

5. On what date were you first wholly unable to work due to this sickness or injury? _____

6. (a) Are you presently working in any occupation for wage or profit? Yes No Part time _____ Full time _____
If "Yes", please explain _____

(b) When do you expect to return to work? Date _____

7. Name all physicians who have treated you since six (6) months prior to your last day worked. (Use additional sheets if needed)
Name: _____ From _____ To _____ Rx? _____

8. Are you insured under any other policies issued by this Company?
If so, please give the numbers. _____

9. I authorize any insurance company, organization, employer, hospital, physician or surgeon to release any information with respect to this disability review form. I certify that the information I have furnished is true and correct. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

Date _____ Signature of claimant _____

To be completed by the employer Group Number _____ Group Effective Date: _____

1. Name of employee _____ SSN _____ Effective-Date _____

2. Date of Hire _____ Age or date of birth as given at that time _____

3. In what occupation was he or she engaged? _____ Salaried ___ Hourly ___
Include job description! _____ Union ___ Non-union ___
Hours Worked _____ per week Salary as of Last Day Worked \$ _____

4. On what date was he or she last at work? _____ Benefit Amt \$ _____ Basic-\$ _____ Supp-\$ _____

5. Why did he or she cease working on that date? _____ Work Related? Yes ___ No ___

6. Please include HIPPA Authorization, Beneficiary Election form, Enrollment card, Training Education & Experience Form

Tel. No. _____ Employer _____
(Include Area Code) Address _____

Date: Mo _____ Day _____ Yr _____ By (Signed) _____

Printed Name _____ Title _____

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT

Attending Physician's Statement of Disability

Name of Patient _____ Date of Birth _____

The patient is responsible for the completion of this form without expense to United HealthCare Insurance Company.

1. History

a) When did symptoms first appear or accident happen? Mo _____ Day _____ Yr _____

b) Date patient was first disabled. Mo _____ Day _____ Yr _____

c) Has patient ever had same or similar condition? Yes No

If "Yes" state when and describe

2. Present Condition

Height _____ Weight: _____

a) Reported symptoms

b) Objective findings/Diagnostic testing

Include results of any x-rays, E.K.G.'s or any other special tests.

c) Is patient _____ Ambulatory? Bed confined? House confined? Hospital confined?

3. Diagnosis Primary:

Secondary:

4. Treatment

Treatment Plan _____

(a) Date of first visit: Mo. _____ Day _____ Yr _____

(b) Date of last visit: Mo. _____ Day _____ Yr _____ Frequency of visits _____

(c) Date of Next Visit: Mo. _____ Day _____ Yr _____ Weekly Monthly

(d) When did you last examine patient? Mo. _____ Day _____ Yr _____

5. Progress

Recovered Improved Unimproved Retrogressed

6. Extent of Disability

For Any Occupation

For Employee's Regular Occupation

(a) Is patient now totally disabled? Yes No Yes No

(b) If no, when was patient able to go to work? Mo. _____ Day _____ Yr _____ Mo. _____ Day _____ Yr _____

(c) If yes, when do you think patient will be able to resume work { Approximate Date - - - - Mo. _____ Day _____ Yr _____ Indefinite - - - - - - - - Never - - - - - - - - Mo. _____ Day _____ Yr _____

(d) If yes, is patient a suitable candidate for a rehabilitation program? Yes No

7. Mental Condition

Is the patient competent to endorse checks and direct the use of their proceeds? Yes _____ No _____

Remarks:

Date _____ Signature (Attending Physician) _____ Degree _____ Telephone _____
Street Address _____ City or Town _____ (or Province) _____ Zip Code _____

Are you related to the patient by blood or marriage? Yes _____ No _____

Participant's Name (Please Print): _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give Unimerica Insurance Company, Unimerica Life Insurance Company of New York, United HealthCare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative: _____ Date: _____

Relationship, if other than Claimant: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7149 Portland ME 04112-7149
Tel 888 299 2070 Fax 800 980 0298