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SYMETRA
MENT | BENEFITS | LIFE

Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

GROUP SHORT TERM DISABILITY CLAIM APPLICATION

Send completed application to:

Claims Department
PO Box 1230
Enfield, CT 06083
Toll Free Number: 1-877-377-6773
Fax Number: 1-877-737-3650

To avoid unnecessary delays, please follow these instructions when applying for disability benefits.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

All four sections of this claim application must be completed:

Section 1:	*Authorization and Disclosures* (to be completed by the employee)
Section 2:	*Employee's Statement* (If you have already returned to work full-time or if you are filing a maternity claim, only complete questions #1 through #15. For all other claims, answer all questions in this section)
Section 3:	*Employer's Statement*
Section 4:	*Physician's Statement*

When ALL sections of this form have been completed, please fax or mail it to us. Use the fax number or address above that corresponds to the type of disability for which you are applying.

It is your responsibility and the responsibility of your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Authorization and Disclosures

Section 1: To Be Completed By Employee

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

TO:

- Physicians and other Medical Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
- Group Policyholders, Contract Holders/Vendors, Health Benefit Plan Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers and Pre-Paid Health Plans
- Pharmacies
- State Vocational Rehabilitation agencies and other providers of Rehabilitation Services
- Attorney Representatives

You are authorized to provide any information related to my medical condition and to job modifications/accommodations with my current or future employer to:

Symetra Life Insurance Company,
The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
Claims investigators, attorneys, and service consultants and other personnel involved in the administration, evaluation, analysis and management of the plan and/or claim.

This includes, but is not limited to, any:

Records, test results, data, and information about medical care, history, diagnosis, prognosis, treatment, and supplies;
Employment-related information;
Income-related information;
Information from credit reporting bureaus or other consumer reporting agencies; and
Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, analyzing, managing and / or administering my claim for short term disability benefits, long term disability benefits, salary continuation, workers' compensation and/or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), understa9 0 Tiss T*( )Tj(rk)]TJoy eal

Authorization and Disclosures

Symetra Life Insurance Company | Claims Department
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Employee's Statement

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1	Employee Name		2 Social Security No.
	Street/Box/Apt.		3 Preferred Daytime Phone No. Other Phone No.
	City, State, Zip	4 Employee Home Email Address	5 Date of Birth

6	Height	7 Weight	8 Dominant Hand ☐ Left ☐ Right	9 ☐ Male ☐ Female

10	Employer Name	11 Occupation	12 List Occupation Duties

13	Date of accident or date of first symptoms	14 Last Day Worked	15 Are you unable to work due to: (check one) ☐ Injury ☐ Illness ☐ Pregnancy

16	Date you Returned to Work	☐ Full Time ☐ Part Time
17	If you have not returned to work, when do you expect to return?	☐ Full Time ☐ Part Time

18 Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms. Please indicate if you have had a prior disability leave for this same condition.

19 Is your accident or illness related to your occupation? ☐ No ☐ Yes
If yes, explain:

20 Have you filed a Workers' Compensation Claim? ☐ No ☐ Yes If no, do you intend to? ☐ No ☐ Yes
If no, explain:

21 When were you first treated for your illness or accident?

Hospital	Address	Date(s)
Doctor	Address	Date(s)

22 Have you ever had same or similar condition in the past? ☐ No ☐ Yes If yes, list name and address of Hospital/Doctor below

Hospital	Address	Date(s)
Doctor	Address	Date(s)

23 Are you receiving any of the following? (Check each benefit you are receiving)

	Amount	Begin date	End date		Amount	Begin date	End date
☐ Workers' Compensation	$_____	_____	_____	☐ Unemployment	$_____	_	

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Employer's Statement

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1	Employee Name		2 Phone No.
	Street/Box/Apt.		3 Social Security No.
	City, State, Zip		4 Date of Birth
5	Date of Hire	6 Regularly Scheduled Hours Per Week	7 Employee's STD Insurance Effective Date
8	Employee's LTD Insurance Effective Date		9 Occupation (A job description is required.)

10 Does employee contribute toward the STD premium? (Include payroll stub with premium deductions) ☐ No ☐ Yes
If yes, ☐ Pre-Tax ☐ Post-Tax
If Post Tax, _____% paid by employer _____% paid by employee

11	Policy No.	12 Policy Division No.	13 Policy Class

14 Employee's Work Schedule ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal ☐ Union ☐ Non-Union

15 Check Regular Workdays ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

16 If not at work when disability began, check status and provide date
☐ Terminated ☐ Leave of Absence ☐ Other:
☐ Laid Off ☐ Sick Leave _____
☐ Vacation ☐ Resigned
Date _____

17 How was employee paid? (check frequency and types)
Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly
Type(s): ☐ Hourly ☐ Bonus ☐ Salary ☐ Commission

18 Salary Prior to Date Last Worked
Base Weekly Wages $ _____
W-2 Earnings $ _____
Overtime $ _____
Commissions $ _____
Bonus $ _____

19 Date Last Salary Increase

20 Employee Work Schedule at Time Last Worked
_____ Days per week _____ Hours per week

21 Prior off-work period for the same condition: from_____through_____

22 Coverage under a prior STD policy? ☐ No ☐ Yes If yes, provide the inclusive dates of coverage: From_____Through_____
Was employee insured under your prior LTD policy? ☐ No ☐ Yes If yes, provide the inclusive dates of coverage: From _____ Through _____
Life Waiver of Premium coverage? ☐ No ☐ Yes If yes, effective date of coverage and Class _____

23	New York DBL? ☐ Yes New Jersey TDB? ☐ Yes (If yes, complete reverse side)	24 Date Last Worked	25 Hours Worked That Day	26 First Day Out

27 Has Employee Returned to work?
☐ No ☐ Yes If yes, Date _____
☐ Full Time
☐ Part Time

28 Date Paid Through _____ For
☐ Salary Continuation ☐

Employer's Statement

Section 3: Continued

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

32 Does your company have a rehire or return to work policy for disabled employees? ☐ No ☐ Yes
What is the name of the person we should contact if we identify a return to work option?

33 Employee's medical insurance carrier or HMO (provide policy or ID No.)

Name _____

Address _____

34 Only complete this information if the employee is eligible to receive New York (DBL), or New Jersey (TDB).

Employee Name	Social Security No.	Weekly Wages Last Day Worked
		$

In the following spaces show dates and claimant's GROSS earnings in New York and/or New Jersey employment during the last weeks prior to the week disability began.

	Calendar Week End Date	**Gross Wages**
Calendar Week in Which Disability Began	_____	$ _____
Prior Week Before Disability	_____	$ _____
2nd Week Before Disability	_____	$ _____
3rd Week Before Disability	_____	$ _____
4th Week Before Disability	_____	$ _____
5th Week Before Disability	_____	$ _____
6th Week Before Disability	_____	$ _____
7th Week Before Disability	_____	$ _____
8th Week Before Disability	_____	$ _____
	Total	$ _____

35 Notice to Employers – Tax Services.
We will provide the tax services agreed upon at the time the policy was sold. Please contact the Claims Department