



Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141

Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496

cinfin.com ■ 513-870-2000

Disability Income or Waiver of Premium Claim Packet

**If you need assistance filing your claim, please contact us
888-212-6970 or life-healthclaims@cinfin.com**

This packet must be completed by the insured, employer and the attending physician and returned to us for consideration of benefits. Please keep a copy, along with any attachments, for your records. All questions must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration.

The Cincinnati Life Insurance Company is not responsible for any expenses associated with the completion of this packet.

Instructions:

- **Claimant's Statement:** Must be completed, signed and dated by the insured.
- **Employer's Statement:** Must be completed, signed and dated by your employer.
- **Attending Physician's Statement:** Must be completed, signed and dated by the physician primarily responsible for your care.
- **Authorization for Release of Information:** Must be signed and dated by the insured or personal representative.

Please enclose any additional information that you feel will assist us in evaluating your claim.

Return completed forms to: The Cincinnati Life Insurance Company
Disability Income Claims
P.O. Box 145496
Cincinnati, OH 45250

Life-HealthClaims@cinfin.com ■ Phone: 888-212-6970 ■ Fax: 513-870-2969

Forms included:

Claimant's Statement Form CLI-8563-CA (1/23)

Employer's Statement Form CLI-8981

Attending Physician's Statement Form CLI-8982

Authorization for Release of Information Form CLI-8513 (9/21)

Questions pertaining to your job

Normal work schedule prior to disability
 ___ days per week
 ___ hours per week

Gross annual salary (during 12 months prior to disability,
 from this employer only) \$ _____

Do you have any secondary employment? Yes No Gross annual salary \$ _____
 If yes, name and address of secondary employer and type of business: _____

Telephone number of secondary employer: _____

Give detailed description of job duties and skills required to perform your job (attach job description or resume if available):

Education/Experience	Number of years completed	
Primary/high school:	_____	
Trade school:	_____	Skill trade: _____
College:	_____	Major/Minor: _____
Post graduate work:	_____	Area(s) of study: _____ Degree: _____
Other continuing education courses (keyboarding, software, classes, etc.): _____		

Does your occupation require a license or other special privilege? Yes No If yes, has your license or privilege now or ever been canceled, revoked, suspended, limited or under review of prosecution by the licensing body granting you license?
 Yes No If yes, please provide details: _____
 State license(s): _____ License(s)/certificate #: _____

Questions pertaining to other disability benefits

If you are receiving Social Security Disability Insurance (SSDI) or other benefits, attach documentation to verify amount (e.g., SSDI award letter).

Are you receiving income from any of the following:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE ENDED	PAID WEEKLY	PAID MONTHLY
<input type="checkbox"/>	<input type="checkbox"/>	Sick pay?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local or state disability income plan?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment compensation disability?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security benefits (disability or retirement)?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement income (normal, early or disability)?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Insurance carriers?	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other? (describe)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Have you applied or do you plan to apply for benefits described above? Yes No
 Type _____ Date application filed _____
 Type _____ Date application filed _____

If you are receiving benefits from another insurance company, please provide the name, address and phone number of the company and your policy number: _____

Questions pertaining to your disability

What is the nature of your disability?	When did you first notice condition or when did injury occur?	When did you first consult a physician for treatment of this condition?
Have you suffered from similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____		
Is disability the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe accident in detail: _____ _____		
Was the accident work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No Where did accident occur? _____ Provide accident report if available.		
Date last worked by reason of present disability: _____ Date returned to part-time work: _____ Date returned to full-time work: _____		
Is your sickness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ Did you file for workers' compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you confined to: HOSPITAL <input type="checkbox"/> Yes <input type="checkbox"/> No HOME <input type="checkbox"/> Yes <input type="checkbox"/> No BED <input type="checkbox"/> Yes <input type="checkbox"/> No If hospital confined, give name and address of hospital: _____ _____		
Confined from _____ through _____		
Do you now or in the future expect to resume part-time or full-time work of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give nature of work and approximate dates: _____ _____ _____		

Current Daily Activity

1. Describe how you currently spend your time and the daily activities that you engage in. How is a typical day spent?
Please be specific.
Morning _____
Afternoon _____
Evening _____

2. Please describe your activities prior to the date your disability began.
Morning _____
Afternoon _____
Evening _____

3. Have you been doing any work from home or have you been to your place of business since your disability began?
If yes, please provide dates and description of the activities: _____

FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with:

(a) Pregnancy Yes No Date of last menstrual period: _____ Expected date of delivery: _____

(b) Delivery Yes No Actual date of delivery: _____ Vaginal C-Section

(c) Post Partum Yes No If yes to any of these, please specify in detail: _____



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EMPLOYER'S STATEMENT

Policy # (s) _____

Employer's name: _____ Employer's phone #: _____

Employer's address: _____

Employee's name: _____ Employee's SSN: _____

Employee's address: _____

Original date of hire: _____

Effective date of coverage: _____

1. Date employee last worked: _____

2. Date returned to work: _____ Full-time Part-time

3. Employee's job title: _____

4. Explain the tasks the employee normally performs. **Attach a written job description if available.**

5. Type of employment: Salaried Hourly Independent contractor
 Partner Retired Terminated

6. Rate of pay: \$ _____ Weekly Bi-weekly Monthly Other: _____ (Specify)

7. Number of hours worked in a normal week: _____

8. W-2 earnings for last calendar year: \$ _____

9. Expected date of return if employee has not returned to work: _____

10. Is employee's job being held for them? Yes No

11. If employee cannot return to former occupation, would the company provide an alternate position? Yes No
If no, please explain: _____

12. Does your company have group disability income coverage? Yes No

If yes, please provide name, address and phone number of the insurance company:

13. Is employee eligible for group disability benefits? Yes No

If yes, has your employee applied? Yes No

If no, please explain: _____

14. Was disability the result of a work-related accident or sickness? Yes No

15. Has a worker's comp claim been filed? Yes No If yes, please provide details and name of company:

16. Is premium for this disability policy paid by employer? Yes No
Percent paid by employer: _____% Percent paid by employee: _____% pre-tax post-tax

17. Please provide further information about the employee's work. What are activities in a typical 8-hour day?

	Never	0-2 hours	2-6 hours	Over 6 hours	
Bend/stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach above head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	_____ hours at a time	_____ hours total per day			
Standing	_____ hours at a time	_____ hours total per day			
Walking	_____ hours at a time	_____ hours total per day			
Driving	_____ hours at a time	_____ hours total per day			
Lifting	_____ hours at a time	_____ hours total per day			Usual number of _____ lbs.
Carrying	_____ hours at a time	_____ hours total per day			Usual number of _____ lbs.

18. Please advise of any educational requirements to complete this job (e.g. college degree, training, etc.): _____

19. Please advise if you are willing to make modifications to the employee's occupational duties as required by the Americans with Disabilities Act. Yes No

20. How has the employee's disability interfered with the performance of this occupation?

21. Please provide any additional information regarding the occupational requirements of this position, or regarding this employee's disability: _____

I HEREBY DECLARE THAT ALL STATEMENTS PROVIDED ON THE EMPLOYER'S STATEMENT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name and title

Phone number

Name of company

Fax number

Date completed

Email



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ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for any expenses associated with the completion of this form. Continue on a separate page if necessary.

Name of patient: _____ Date of birth: _____
Employer name: _____ Group/policy #: _____

1. 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: _____

- (f) Name and address of referring physician(s): _____

List all active diagnosis codes and dates of exams below 2. DIAGNOSIS (including any complications)

- (a) Diagnosis codes: _____
- (b) Date of last examination: _____
- (c) Subjective symptoms: _____

- (d) Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings): _____

- (e) How many more visits do you anticipate and at what frequency? _____

DIAGNOSIS (including any complications)

- (a) Diagnosis codes: _____
- (b) Date of last examination: _____
- (c) Subjective symptoms: _____

- (d) Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings): _____

- (e) How many more visits do you anticipate and at what frequency? _____

3. DATES OF TREATMENT

- (a) Date of first visit: _____
- (b) Date of last visit: _____
- (c) Frequency: Weekly Monthly Other (Specify): _____

4. NATURE OF TREATMENT (including surgery and medications prescribed, if any, include dosage and frequency)

10. RETURN TO WORK PLAN

- (a) Have you discussed a return to work plan with your patient? Yes No
- (b) Projected return to work date: _____ Full time Reduced hours Number of hours: _____
- (c) Please identify your recommendations for any job modifications that would enable the patient to work: _____

11. COMPLIANCE

- (a) Compliance with treatment: Yes No
- (b) Has the patient been discharged from your care? Yes No If yes, please provide date and reason for discharge: _____

12. CURRENT FUNCTIONAL ABILITY

- (a) In an 8-hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (Please indicate number of hours):
 - ____ Hrs. sedentary activity 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.*
 - ____ Hrs. light activity 20 lbs. maximum lifting, carrying 10-lb. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.*
 - ____ Hrs. medium activity 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.*
 - ____ Hrs. heavy activity 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.*

* Reference Dictionary of Occupational Titles

- (b) Please check appropriate box:

	Occasionally (0% to 33%)	Frequently (34% to 66%)	Continuously (67% to 100%)
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/pull	<input type="checkbox"/> # of lbs. _____	<input type="checkbox"/> # of lbs. _____	<input type="checkbox"/> # of lbs. _____
Lifting	<input type="checkbox"/> # of lbs. _____	<input type="checkbox"/> # of lbs. _____	<input type="checkbox"/> # of lbs. _____

What is this assessment based on? observed activity measured capacity physical therapy report

- (c) Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (including, driving, working at heights, etc.) Please be specific: _____

- (d) Is your patient able to work a reduced number of hours? _____

PHYSICIAN INFORMATION

Attending Physician's Signature: _____ **Date:** _____

Physician's Name (please print): _____

Degree/Specialty: _____

Telephone Number: _____ Fax number: _____ Tax ID#: _____

Office Address: _____
Number/Street

City or Town _____ State _____ ZIP Code _____

(PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE.)



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Authorization for Release of Information

Insured's Name: _____ Insured's Date of Birth: _____
Please Print

I, the Insured named above or the Personal Representative acting on behalf of the insured, hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical or medically-related facility; the Veterans Administration; Social Security Administration; Internal Revenue Service; financial institution; employer; consumer reporting agency; law enforcement agency or governmental entity; prescription database service; MIB or any organization that has any medical or nonmedical information regarding the Insured to give all such information to The Cincinnati Life Insurance Company or its authorized representative.

This shall include but not be limited to any information regarding the Insured's health history, including all consultations and treatments about mental illness and the use of drugs, alcohol or tobacco (excluding psychotherapy notes); prescription drug information; Human Immunodeficiency Virus (HIV) infection; Acquired Immune Deficiency Syndrome (AIDS); and the diagnosis, treatment or prognosis of any physical condition.

The patient or the patient's representative must read and sign the following statements:

1. I understand that this information will be used to evaluate my claim for insurance benefits and if I refuse to sign this authorization to release my records, The Cincinnati Life Insurance Company may not be able to investigate and/or pay my claim.
2. Information disclosed pursuant to this authorization may not be subject to state or federal privacy regulations and laws.
3. I may revoke this authorization at any time by sending a written request to The Cincinnati Life Insurance Company at the above address, but such revocation will not affect information that has already been requested, collected, used or disclosed in reliance on this authorization.
4. This authorization will be valid from the date signed for a period of two years unless revoked in writing.
5. Any request that I have made to my medical providers to restrict information disclosed does not apply to this authorization.
6. I may obtain a copy of this authorization form by sending a written request to The Cincinnati Life Insurance Company at the above address.
7. A photographic copy of this authorization shall be as valid as the original.

Signed on: _____
Month Day Year

Policy number(s) _____

Print Name of Insured or Personal Representative

Signature of Insured or Personal Representative

Relationship to Insured
(indicate if Personal Representative)