EMPLOYEE REQUEST FOR INFORMATION

Mail this completed form to:
Aetna Life Insurance Company
P.O. Box 14554
Lexington, KY 40512-4554
Phone: **877-465-0424**
Fax: **866-888-2308**

This notice should be **completed by Employer and Employee,** using BLUE or BLACK ink, and faxed/mailed to Aetna Life Insurance Company in order to initiate a disability claim. Neither the furnishing of this form, nor its acceptance by the company, shall be construed as an admission of liability or a waiver of any of the provisions of the plan document.

EMPLOYER INFORMATION *(To be completed by the Employer.)*

Employer's Name						EIN Number	
Employer's Address: Street			City		State	Zip	
Work Location (if different from the above)			Supervisor's name and telephone number				
Does member have both Aetna Disability and Health Insurance? ☐ Yes ☐ No	Aetna Disability Control Number	Disability Suffix	Disability Account	STD	LTD	Disability Plan	
Complete all applicable information.	Aetna Health Plan Control Number		Health Plan Suffix	Health Plan Account	Health Plan Summary Code		
Employee's Name *(Last, First, Middle Initial)*			Employee Gender ☐ Male ☐ Female		Employee's Social Security Number		
Date of Hire *(MM/DD/YYYY)*	STD Coverage Effective Date *(MM/DD/YYYY)*	LTD Coverage Effective Date *(MM/DD/YYYY)*	Date Last Worked *(MM/DD/YYYY)*		Was more than a half day completed? ☐ Yes ☐ No		
Employee's Occupation	Occupation is: ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy		Date Salary continuation was paid through *(MM/DD/YYYY)*		Reason employee ceased work		
Employee's earnings are: $ _____ ☐ Annually ☐ Monthly ☐ Weekly ☐ Hourly					Number of hours per week		
The portion of the cost of coverage that is paid by the employee with post-tax dollars is non-taxable. What percentage of the cost of coverage is paid by the employee in this manner?					STD _____% LTD _____%		

If premium deductions are to be withheld please list the amounts (weekly).

	Medical	Life	Dental	AD&D	Vision	FSA – Health	FSA – Dependent	LTD	Other
Amount	$	$	$	$	$	$	$	$	$
Pre-tax $	%	%	%	%	%	%	%	%	%
Post-tax $	%	%	%	%	%	%	%	%	%

The following is applicable only if the employee also has group life insurance with Aetna:

Basic Life Control Number	Control Suffix	Claim Account	Plan	Amount of Basic Insurance in Force on Date Last Worked $	
Supplemental Life Control Number	Control Suffix	Claim Account	Plan	Amount of Supplemental Insurance in Force on Date Last Worked $	
Type of Provision *(check one)*: ☐ Premium Waiver ☐ DBO-AID ☐ Lump Sum ☐ Group Universal Life ☐ PTD/ Installment			Date Insurance Took Effect	Effective Date Insurance Discontinued if Not in Force	
Was Claimant Required to Submit Evidence of Insurability? ☐ No ☐ Yes, give date submitted _____			**Supplemental Insurance Required Information: Enrollment forms and/or Screen Prints for current year as of date last worked and 2 years prior.**		
Last Contribution Covered Period Ending ***(complete only if claimant contributed part of premium)***			**If Retired, Provide Retirement Date and Copy of Pension Acceptance.**		
Name and phone number of person providing the above information:				Date (MMDDYYYY)	

EMPLOYEE INFORMATION *(To be completed by the Employee. **Misrepresentation** section on **back page MUST** be signed.)*

Employee's Address: Street		City	State	Zip
Telephone number	May we leave messages on your answering machine? ☐ Yes ☐ No		Date of birth *(MM/DD/YYYY)*	
Date first missed work due to disability *(MM/DD/YYYY)*		Date returned/will return to work *(MM/DD/YYYY)*		
What is the nature of your disability (diagnosis and/or ICD/CPT Code)?		Were you hospitalized due to this condition? ☐ Yes ☐ No If Yes, what date were you hospitalized on?		
Is this condition work related? ☐ Yes ☐ No	Is this condition the result of an accident? ☐ Yes ☐ No	Is this condition the result of a motor vehicle accident? ☐ Yes ☐ No		
What is your occupation?	Briefly describe your job duties			
What is your doctor's name?	What is your doctor's address and phone number?			
Has your doctor recommended that you stay out of work because you cannot perform your job at this time? ☐ Yes ☐ No If Yes, how long do they expect you to remain out of work?		Briefly describe how your condition prevents you from working		
Have you been disabled as a result of this condition before? ☐ Yes ☐ No If Yes, when and how long?		Are you receiving any other form of income? ☐ Yes ☐ No If Yes, please describe:		

Employee's Name *(Last, First, Middle Initial)* **REQUIRED**

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Ohio and Pennsylvania Residents: 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee's Signature	Date *(MM/DD/YYYY)*