



Permanent Disability Claim Report

Life and Disability Benefits

GE Financial Assurance
Employer Services Group

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

Type(s) of Claim Check appropriate box(es) below

Dismemberment Benefit Waiver of Premium-Life Benefit Major Medical Request

Employer's Statement

Name of Claimant (Last, First, M.I.) - Please Print			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.				

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give such information to GE Group Life Assurance Company (GEGLAC) and its legal representatives: Any physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person, any employer, group policyholder or certificateholder.

I understand that the information released to GEGLAC will be used in evaluating my claim for insurance benefits. GEGLAC may redisclose such information for that purpose to the employer or union connected with the group insurance coverage involved herein, the group policyholder or certificateholder or their representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of GEGLAC. This information may also be redisclosed as otherwise specifically permitted or required by law.

This authorization extends to and includes any information relating to alcohol or drug abuse or mental health care. If the record contains information relating to HIV test results, AIDS, alcohol or drug abuse, or mental health care, enough of this information is also to be released to accomplish the purposes for which the information is requested. This authorization or a photocopy of it will be valid for the duration of the claim. The information released to GEGLAC will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee	Telephone Number	Date Signed
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State Law, in some states, requires the following: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either; (1) Files a statement of Claim that contains any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. **Violations are subject to criminal prosecution and may also result in substantial civil penalties.**

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
	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.			
	<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			
MENTAL/NERVOUS IMPAIRMENT (if applicable)	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			
	(a) Is patient now totally disabled from all occupations? <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) What duties of patient's job is he/she incapable of performing?	
DEGREE OF DISABILITY	(c) Do you expect an improvement in the future? (If "yes", when will patient recover sufficiently to perform work duties?) <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Is patient a suitable candidate for future rehabilitation services? (i.e., Cardiopulmonary program, speech therapy, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
REHABILITATION	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	

Dismemberment Claims Only

Loss of Sight		Loss of Limb	
Date of Loss of Vision		Date of Loss	
Diagnosis in Regard to Injured Eye		Diagnosis in Regard to the Loss	
Is the patient totally blind? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the loss due to accidental means? Explain:	Date of Accident
If not totally blind, what was vision at last observation?			
Was loss due to accidental means? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the loss due to a physical infirmity or disease? Explain:	
Date of Accident			
Was loss due to a physical infirmity or disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		What was the anatomical level of amputation?	
Explain:			
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