ADA Insurance Plans
from GREAT-WEST LIFE
ADA American Dental Association®

Great-West
LIFE & ANNUITY INSURANCE COMPANY

ADA DISABILITY INCOME PLAN
P.O. BOX 1700
DENVER, COLORADO 80201
1-800-537-2033

ADA DISABILITY INCOME PLAN

ADA DISABILITY INCOME INITIAL CLAIM PACKET

SUBMISSION INSTRUCTIONS

***To ensure prompt assessment** of your Disability Income claim, please follow these instructions when submitting the initial claim.

Your initial documents consist of three (3) forms.

HIPPA Compliant Authorization for Release of Medical Information
Member Statement/Authorization to Obtain Information
Attending Physician's Statement

INSTRUCTIONS TO MEMBER:

- Answer all questions in full, date and sign Member Statement and Authorization to Obtain Information form.
- Return Member Statement and Authorization to Obtain Information to us immediately.
- Sign and date top portion of Attending Physician's Statement and provide to treating physician to complete.
- ***• Advise Attending Physician to attach copies of laboratory, x-rays, diagnostic test reports and clinical notes covering the 12-month period preceding total disability through the present.**
- If your disability is expected to last longer than 90-days we will require a signed, complete copy, including all schedules, of your individual and business Federal Income Tax Return for the best year from the 4-years prior to your disability to verify your pre-disability income.

INSTRUCTIONS TO ATTENDING PHYSICIAN: NOTE: All of the following are important and necessary for prompt assessment of this claim:

- Complete Attending Physician's Statement in detail.
- Form must be dated and signed in physician's own handwriting.
- ***• Attach copies of laboratory, x-rays, diagnostic test reports and clinical notes covering the 12-month period preceding total disability through the present.**
- Mail completed form and records to Great-West.

HIPAA Compliant Authorization for Release of Medical Information

_____ _____/_____/_____
Name of insured/patient (please type or print) Date of Birth

I authorize_____,
any health plan, physician, health care professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to, pharmacies, pharmacy benefits managers, and insurers, medical facility, or other health care professional that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information and any other protected health information concerning me to Great West Life & Annuity Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West Life & Annuity may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have or have applied for with GreatWest Life & Annuity.

This authorization shall remain in force for 36 months following the date of my signature below and a copy of this authorization is a valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Great-West Life & Annuity has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be redisclosed by (the recipient) except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Great-West Life & Annuity may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____
Signature of Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

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ADA DISABILITY INCOME CLAIM REPORT

MEMBER STATEMENT

1. Name:_____ Plan No: GDH 1105
2. Home Address: _____
3. Home No.: (_____) _____ 4. Cell No.: (_____) _____
5. Date of Birth: ____/____/____ 6. ADA Certificate #_____ 7. Height:_____ 8. Weight: _____
9. Right or Left Hand Dominant?_____
10. Dental Specialty or Occupation Prior to Disability: ☐ General Dentistry ☐ Orthodontist ☐ Periodontist
    ☐ Dental Surgeon ☐ Other _____
    ☐ Sole Proprietor ☐ S Corp ☐ Partnership ☐ Regular Corporation ☐ Other _____
11. Employment Address:_____
    _____ 12. Office No.: (_____) _____
13. Tax ID #: _____ 14. Fax No.: (_____) _____
15. What is the nature of your present disability? _____
16. Is present condition due to an accident? ☐ Yes ☐ No Date: ____/____/____
17. Describe how and where accident occurred. If motor vehicle accident, attach a copy of the police/accident report:
    _____
18. What date were you unable to practice dentistry? ____/____/____ Last Date Worked ____/____/____
19. Did you reduce your hours prior to this date? ☐ Yes ☐ No If yes, please provide date ____/____/____ and
    Number of hours and days per week you normally practice: _____Hours / day _____Days / week
    What days and hours do you <u>now</u> practice? _____Hours / day _____Days / week
20. Have you resumed practicing dentistry? ☐ Yes ☐ No
    If yes, date you returned Part Time____/____/____ _____Hours / day ____Days/week Full Time____/____/____
21. What are your present activities of daily living?_____
    _____
    If you go into your office, include what specific tasks you perform: _____
    _____
22. When did you first receive medical treatment? _____
23. Treating physician's name: _____
24. Address:_____ 25. Telephone No.: (_____) _____
26. Have you ever been treated for the same or a related condition? ☐ Yes ☐ No

MEMBER STATEMENT (continued)

27. List the names and addresses of all physicians or hospitals where you have been treated for the same or a related condition at any time:

NAME	ADDRESS	PHONE NO.	CONDITION	DATES

28. If you have returned to work and wish to claim a Residual Disability Monthly Income Benefit you will need to provide documentation of your "Prior Monthly Income" as well as your "Current Monthly Income."

    a. "Monthly Income" means gross monthly income from salary, wages, fees or other remuneration earned for professional services performed by the insured **Member**. It does not include dividends, rents, royalties, annuities or other forms of unearned income.

    b. "Prior Monthly Income" means the average "Monthly Income" earned by the insured **Member** during the greater of either the 12 or 24 consecutive month period which ends on the first day of **Total Disability** which preceded the "Residual Disability" for which claim is made. Please provide monthly revenue statements.

    c. "Current Monthly Income" means the **Member's** "Monthly Income" during each month the **Member** claims Residual Disability Monthly Income Benefits under this policy.

29. Do you have plans to sell your practice or your share of the partnership or P.C.? ☐ Yes ☐ No

    Expected closing date of sale_____/_____/_____

30. Do you have any other disability income coverage ☐ Yes ☐ No or office overhead expense coverage? ☐ Yes ☐ No

31. List the names and policy numbers of all other insurance carriers through which you carry disability income or office overhead expense coverage:

INS. COMPANY	ADDRESS	POLICY NUMBER	TYPE OF COVERAGE	AMOUNT

32. **Other Sources of Income.** -- Please indicate all sources of income:

	Receiving		Amount of Benefit		
	Yes	No	Weekly	Monthly	Effective date of benefit
Salary Continuance	☐	☐			
Primary Social Security	☐	☐			
Worker's Compensation	☐	☐			
State Disability	☐	☐			
State Unemployment	☐	☐			
Auto No Fault Benefits	☐	☐			

Please attach copies of original Award Certificates/Letters.

Do you plan to apply for any of the benefits described above? ☐ Yes ☐ No

Type of benefit:_____ When will you apply? _____/_____/_____

Are you presently engaged in another business or occupation other than Dentistry? ☐ Yes ☐ No

(a) If yes, provide the following information:
Date you first engaged in other business or occupation _____/_____/_____.
Present business or occupational activities:\

(b) How many hours per day and days per week are you engaged in any business or occupation? Hours per day Days per week

NOTE: Please send a complete copy, signed by you, including all schedules, of your Personal and Business Income Tax returns for the best year from the 4 (four) years prior to disability to verify your pre-disability income.

By furnishing this blank and investigating the claim, The Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the Plan.

NOTICE – Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.

Planholder Date

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ATTENDING PHYSICIAN'S INITIAL STATEMENT

Patient's Name _____

I hereby authorize the release to my Insurer any information requested in reference to this claim.

Group Plan Number **1105**

Date ____/____/____ Signature of Patient _____

To Physicians:
The patient is responsible for the securing of this form and any charge which may be made for its completion. Please complete the sections relating to your patient and strike out nonapplicable areas. This form should be mailed directly to Great-West Life.

1. History

(a) Date symptoms first appeared or accident happened. ____/____/____

(b) Date patient first consulted you for this condition. ____/____/____

(c) From what date did you recommend patient cease work due to his/her condition? ____/____/____

(d) Date of first visit ____/____/____

(e) Date of last visit ____/____/____

(f) Frequency of visits:
☐ Weekly ☐ Monthly ☐ Other

2. Diagnosis (including complications)

(a) Primary _____

Secondary _____

(b) ***IMPORTANT Clinical findings (attach copies of laboratory, x-ray reports, diagnostic test reports and clinical notes covering the 12-month period preceding total disability through the present.)**

_____

_____

(c) List hospitalizations (if applicable)

Names and Addresses of Hospitals	Dates of Inpatient Admission	Dates of Outpatient Care.
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

List names and addresses of other treating physicians and/or referrals

Name	Address	Phone No.	Date of Last Visit
			/ /
			/ /
			/ /
			/ /
			/ /

ATTENDING PHYSICIAN'S STATEMENT (continued)

3. Treatment

(a) Recommended treatment and projected duration of treatment program _____

_____

(b) Is patient following recommended treatment? ☐ Yes ☐ No If no, explain _____

_____

(c) Date and description of surgery (if applicable) ____/____/____ _____

_____

Name and Address of Surgeon _____

_____

Complete appropriate section, if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

4. CARDIAC

(a) Blood pressure on last visit . . . . . .

(b) Functional capacity (American Heart Ass'n)

Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐

Class 3 (Marked limitation) ☐ Class 4 (Complete limitation) ☐

(c) Was patient in Cardiac Rehab Program? ☐ Yes ☐ No

5. VISUAL IMPAIRMENT

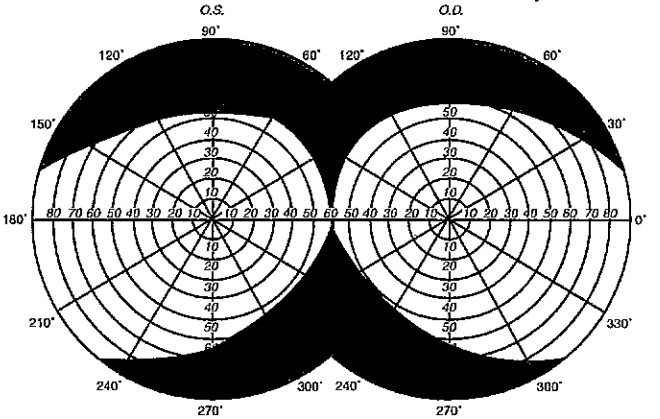
(a) What was vision at last observation? With Glasses. . . . . Without Glasses . . . . .

(Snellen Notation)

O.D._____ O.S._____ Mo._____Day_____19___

O.D._____ O.S._____ Mo._____Day_____19___

(b) If fields of vision are contracted, show construction on chart.



(c) Date **corrected** vision was irrecoverably reduced to 20/200 or less in the better eye . . . . . .

(d) Vision can be restored in whole or in part by. . . . . .

Mo._____Day_____19___ O.D. ☐ O.S. ☐

O.D. Lenses ☐ Treatment ☐ Operation ☐ Not restorable ☐

O.S. Lenses ☐ Treatment ☐ Operation ☐ Not restorable ☐

6. Physical Capacity

(a) In a work day, patient can stand/walk:

(Hours at one time)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

(TOTAL hours during day)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

In a work day, patient can sit:

(Hours at one time)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

(TOTAL hours during day)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

(b) Patient can lift/carry:

	Never	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5 hrs.+
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

6. **Physical Capacity (cont.)**

(c) Patient is able to:	Minimally	Occasionally	Frequently	Continuously
a. Stoop (bend at waist)	☐	☐	☐	☐
b. Kneel (coming to rest on knees)	☐	☐	☐	☐
c. Ascend, descend ladder	☐	☐	☐	☐
d. Ascend, descend stairs	☐	☐	☐	☐
e. Push/pull	☐	☐	☐	☐
f. Reach above shoulder level	☐	☐	☐	☐
g. Crawl	☐	☐	☐	☐

(d) Use of hands for repetitive action:				
Manual dexterity (hold, grasp, turn)	☐	☐	☐	☐
Finger dexterity (pinch, pick, use keyboard)	☐	☐	☐	☐

(e) Is a formal Functional Capacity Evaluation necessary? ☐ Yes ☐ No

(f) Remarks
Other special medical considerations/functional limitations

_____

_____

_____

_____

(g) Do you believe these physical capacities to be permanent? ☐ Yes ☐ No

7. **Physical Impairment (*as defined in US Dept of Labor Dictionary of Occupational Titles) Please offer your recommendations:**

☐ Class 1 - No limitation of functional capacity; capable of heavy work* . . . . . .No restrictions (0 - 10%)
☐ Class 2 - Medium/manual activity* . . . . . .(15 - 30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* . . . . . .(35 - 55%)
☐ Class 4 - Moderate limitations of functional capacity; capable of clerical/administrative (sedentary*) activity . . . . . .(60 - 70%)
☐ Class 5 - Severe limitations of functional capacity; incapable of minimal (sedentary*) activity . . . . . .(75 - 100%)

8. **Prognosis**

(a) Has patient made significant progress? ☐ Yes ☐ No

Please explain: _____

_____

_____

_____

(b) What changes do you expect in the near future? _____

_____

_____

_____

_____

(c) When is maximum recovery expected? _____

9. As of what date do you recommend patient to resume work?

☐ Part Time ___/___/___ ☐ Full Time ___/___/___

10. **Psychological Symptoms** - Please complete this section if the primary or secondary diagnosis involves a psychological or psychiatric condition, or if the patient is suffering from symptoms that are psychological in nature.

A. DSM-IV Multiaxial Diagnosis

Axis I _____ **Axis II** _____

Axis III _____ **Axis IV** _____

Axis V: Current GAF _____ **Highest Past Year** _____ **Baseline** _____

B. Subjective Symptoms: _____

C. Secondary Diagnosis (include complications): _____

D. Subjective Symptoms: _____

_____

E. How have the subjective symptoms been verified? _____

_____

F. Objective Findings (Please attach copies of any testing or clinical findings): _____

_____

G. In your opinion do the *objective* findings support the level of subjective limitations reported by your patient:

☐ Yes ☐ No

Please explain your answer _____

H. Complete the following checklist. Add explanations if necessary in the space provided below.

Degree of Impairment (Scale: 0-None; 1-Slight; 2-Moderate; 3-Significant; 4-Severe)

Interpersonal relations	_____
Daily activities-occupational	_____
Daily activities-social	_____
Ability to think and reason	_____
Sustain work performance	_____
Concentration	_____
Present Memory Disturbance	_____
Judgement	_____
Suicidal ideation/intent	_____

I. Affect (Please describe i.e. appropriate; inappropriate; labile, stable, flat): _____

J. Are the patient's problems related to drug or alcohol abuse? ☐ Yes ☐ No

K. Specify any other factors which may have precipitated this condition and which may effect prognosis for recovery.

_____

11. Remarks

Name (Attending Physician)/Please Print	Degree/Board Certification	Telephone	Fax

Street Address	City or Town / State or Province	Zip Code or Postal Code

Signature	Date
	/ /

Stamp or signature other than physician's own signature will not be accepted.

NOTICE - Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.

NOTE: Great-West Life & Annuity Insurance Company assumes no responsibility for any expense incurred in the completion of this statement. When completed, please mail this statement to Great-West.