

## **Applying for Disability**

To apply for disability, you must do two things: participate in an intake interview and complete and submit the attached application forms.

### **Step 1**

First, you must participate in a confidential intake interview, by phone, with a Board of Pensions Disability Specialist. The intake conversation provides valuable information and allows the Board to open a disability claim file for you. It also gives you an opportunity to get answers to questions you may have about the disability claims process.

To request your intake interview, call the Board of Pensions at 800-773-7752 (800-PRESPLAN). Be prepared to provide the following information: your name, social security number, last day worked, and phone number.

### **Step 2**

Next, download and complete the attached disability application forms. Be sure to promptly mail or fax the forms, along with a copy of your job description, to Liberty Mutual at the address or fax number provided on the forms.

If you have questions about the disability claims process, please call Liberty Mutual at 800-838-5290. For questions about your Benefits Plan benefits, please contact Member Services at the Board of Pensions by calling 800-773-7752 (800-PRESPLAN).

We wish you a swift and smooth road to recovery.

## Disability Benefits Application

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Email \_\_\_\_\_

### Employment

Current Employer's Name \_\_\_\_\_ Pin # \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date Employed \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_

Your Job Title *(Please attach current job description or terms of call.)* \_\_\_\_\_

Other current employment *(if any)* \_\_\_\_\_

### Most Recent Previous Occupation

Your Job Title \_\_\_\_\_

Date Employed \_\_\_\_\_

Please describe specific job functions and duties \_\_\_\_\_

### **A** Clergy only

Presbytery \_\_\_\_\_

I participate in Social Security as a minister.  Yes  No

If no, are you eligible for Social Security benefits from previous employment?  Yes  No

### **B** Education/Training/Skills

What is the highest level of schooling you have completed?

Grade School  1  2  3  4  5  6  7 High School  8  9  10  11  12

College  13  14  15  16 Post Graduate  16+

Please list degrees and majors: \_\_\_\_\_

Licenses or certifications held: \_\_\_\_\_

**Member Name**

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Special training:

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Other skills you have acquired through employment, military service, and volunteer activities:

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Please describe your current hobbies and leisure activities:

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**C Medical Information**

In your own words describe your disabling medical condition and symptoms:

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Give approximate date this condition began: \_\_\_\_\_

Did you receive a diagnosis, medical advice, treatment, or medication before the disabling condition began?  Yes  No

If yes, please give dates and descriptions:

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Did an accident or injury cause the disabling condition?  Yes  No

If yes, please note when, how, and where it occurred:

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List hospitalizations or surgeries you have had related to your disabling condition:

Date(s) \_\_\_\_\_ Hospital \_\_\_\_\_

Physician(s) \_\_\_\_\_

Surgical Procedure \_\_\_\_\_

Date(s) \_\_\_\_\_ Hospital \_\_\_\_\_

Physician(s) \_\_\_\_\_

Surgical Procedure \_\_\_\_\_

Are you now hospitalized?  Yes  No If yes, please complete:

Date \_\_\_\_\_ Hospital \_\_\_\_\_

Physician(s) \_\_\_\_\_

Reason for Admission \_\_\_\_\_

List prior major illnesses with dates:

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Please list the name, strength and frequency of all current medications:

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**D Medical Providers**

Since we will contact your physicians/clinicians for information, please provide complete and accurate information about the caregivers treating you for your disabling condition.

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (    )                      Fax (    )  
Last date of service \_\_\_\_\_  
Specialty \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (    )                      Fax (    )  
Last date of service \_\_\_\_\_  
Specialty \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (    )                      Fax (    )  
Last date of service \_\_\_\_\_  
Specialty \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (    )                      Fax (    )  
Last date of service \_\_\_\_\_  
Specialty \_\_\_\_\_

**E Work Status**

When did you become incapable of performing the material duties of your regular occupation because of your condition? \_\_\_\_\_

What is the last date you worked? \_\_\_\_\_

On what date will your salary relationship terminate? \_\_\_\_\_

On what date do you expect to return to work? \_\_\_\_\_

How does your disabling condition prevent you from performing the material duties of your regular occupation? \_\_\_\_\_

**F Other Benefits**

Have you applied for benefits under:	Applied		Date applied	Determination	
	Yes	No		Eligible	Not Eligible
Social Security Disability	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Social Security Retirement	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Benefits	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Workers Compensation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Motor Vehicle Insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Employer's Disability Policy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other Government Programs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other Benefits	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Have you received any payment as a result of your disability from a third party not listed above? \_\_\_\_\_

**Member Name**

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Have you ever received any disability benefit for a previous condition?  Yes  No

If yes, please describe the disability, the benefit source, the dates of disability and disability payments:

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Do you have long-term care insurance?  Yes  No

Have you applied for vocational rehabilitation services?  Yes  No

If yes, provide the organization name, telephone, contact person and status of application:

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Dates:

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If no, please explain:

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I am over 62 and began receiving retirement income from Social Security before my disability.  Yes  No

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**G Authorization**

I declare that to the best of my knowledge and belief, the information provided above is complete and true. I agree that this document and all its contents shall form a part of my enrollment request for disability benefits. The information may be used to decide if I am eligible for coverage. It may also be sent to any organization that performs services in connection with this coverage. I understand that any material misstatement can result in denial of my claim.

Member's Signature

Date

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**Optional Authorization for release of disability records (including medical and employment information).**

This authorizes the Board of Pensions of the Presbyterian Church (U.S.A.) or any representative thereof, to discuss with or furnish to my presbytery and/or employing organization any and all information which may be in the possession or control of the Board of Pensions regarding my DISABILITY BENEFITS, including without limitation information regarding my physical and mental condition, medical and dental history and treatment, employment history, compensation and loss of earnings, and medical expenses, and to allow them to copy any records or documents which the Board of Pensions may have regarding my employment, disability and any physical or mental condition, treatment, charges or reimbursements.

Please consider any copy of this authorization to be as effective as the original. This authorization shall continue in force until revoked by me in writing.

Member's Signature

Date

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**Please send the completed form to:**

Liberty Mutual  
PO BOX 7210  
London, KY 40742-7210  
800-838-5290 FAX: 603-334-0366

# ATTENDING PHYSICIAN'S STATEMENT

This form is to be completed  
without expense to Liberty Mutual and returned  
along with your original claim for benefits or  
by the date requested by the Liberty Mutual Claims Dept.



Group Market Disability Claims  
Liberty Life Assurance  
Company of Boston  
P.O. Box 7210  
London, KY 40742-7210  
1-800-838-5290  
Fax #: 1-603-334-0366

Return to: \_\_\_\_\_

PART A: TO BE COMPLETED BY EMPLOYEE

EMPLOYEE/CLAIMANT NAME: _____	
CLAIM NO.: _____	S.S. NO.: _____ - _____ - _____
EMPLOYER/SPONSOR: _____	DATE OF BIRTH: _____

### AUTHORIZATION TO OBTAIN INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder for purposes of auditing Liberty's administration of claims under the policy, and persons or organizations providing medical treatment or services in connection with my claim.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This authorization shall become effective on the date appearing next to my signature below.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this authorization at any time by written notification to the Plan Sponsor and/or the Company in the Liberty Mutual group of companies to which I submit a claim.

Date

Claimant's Signature (or Authorized Representative)

### PHYSICIAN'S INSTRUCTIONS

**PLEASE NOTE: IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.**

**THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.**

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

<b>1. DIAGNOSIS</b>		
Primary _____	ICD9 _____	
Secondary _____	ICD9 _____	
_____	ICD9 _____	
Has patient ever had the same or a similar condition?    Yes _____    No _____		
If "Yes", state when and describe. _____		
What is your prognosis? _____		
For Pregnancy:		
EDC _____	Date of Delivery _____	Type _____
<b>2. DATES OF TREATMENT</b>		
(a) Date of First Visit _____		(mo/day/yr)
(b) Date of Last Visit _____		(mo/day/yr)
(c) Frequency of Visits _____	Weekly _____ Monthly _____	Other (specify)
(d) Date of First Treatment _____		(mo/day/yr)
(e) Date Symptoms First Appeared / Accident Occurred _____		(mo/day/yr)
(f) Date Patient Advised to Cease Work _____		
(g) Estimated Return to Work Date _____		

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

3. Please describe in detail your PROPOSED TREATMENT PLAN. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan. IDENTIFY ANY RESTRICTIONS you have imposed on your patient at this time.

4. PHYSICAL IMPAIRMENT

- Class 1 - No limitation of functional capacity; capable of heavy work.
- Class 2 - Medium manual activity.
- Class 3 - Slight limitation of functional capacity; capable of light work.
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative activity.
- Class 5 - Severe limitation of functional capacity; incapable of minimum activity.

REMARKS:

5. MENTAL/NERVOUS IMPAIRMENT

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2 - Patient is able to function in most stressful situations and engage in most interpersonal relations (slight limitations).
- Class 3 - Patient is able to engage in only limited stressful situations and engage only in limited interpersonal relations (moderate limitations).
- Class 4 - Patient is unable to engage in stressful situations or engage in interpersonal relations (marked limitations).
- Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations).

REMARKS:

6. CARDIAC IMPAIRMENT (if applicable)

Functional Capacity:  Class 1: No Limitation  Class 2: Slight Limitation  
 (per American Heart Assn)  Class 3: Marked Limitation  Class 4: Complete Limitation

Blood Pressure (last visit): \_\_\_\_\_  
(systolic/diastolic)

7. Date of Next Scheduled Visit

Are you still treating the patient?  Yes  No  
 If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician?  Yes  No

8. Has patient been hospital confined?  Yes  No

Dates of Confinement: From \_\_\_\_\_ to \_\_\_\_\_  
 Was surgery performed?  Yes  No If "Yes", please indicate procedure(s) performed:  
 CPT Code: \_\_\_\_\_ Date Performed \_\_\_\_\_  
 Name and Address of Hospital: \_\_\_\_\_

9. After you have completed this form, please attach copies of the following materials:

- Office notes for the period of treatment or for the last two years
- Test results showing objective findings
- Hospital discharge summary (if applicable)
- Consulting physician's reports (if applicable)

10. REMARKS

Attending Physician's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID No.
Street Address	( ) _____ Telephone No.	( ) _____ Fax No.
City/State/Zip Code	Signature	Date

Authorization to Obtain and Release Information



Group Market Disability Claims
Liberty Life Assurance
Company of Boston
P.O. Box 7210
London, KY 40742-7210
1-800-838-5290
Fax #: 1-603-334-0366

Return to: \_\_\_\_\_

EMPLOYEE/CLAIMANT NAME: \_\_\_\_\_
CLAIM NO.: \_\_\_\_\_ S.S. NO.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
EMPLOYER/SPONSOR: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I authorize any licensed physician, medical provider, hospital, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all of the following information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services:

- 1. Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.
2. Information with respect to: job duties, earnings, employment applications, personnel records, and other work related information; records and information related to any insurance coverage and claims filed; credit information including, but not limited to, credit reports and credit applications; other financial information including bank records; complete copies of Federal and State tax returns; including attachments; and academic transcripts.
3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly Supplemental Security Income payment amounts, entitlement dates, information from my Fact Query, and any benefits to which my dependents may be eligible under my record. This information may also be released to my employer for administration of my employer sponsored benefits.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder and its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law. I also understand that, to the extent reasonably necessary, information obtained may be released to other insurance companies or insurance support organizations to detect or prevent criminal activity, fraud, material misrepresentation, or material non-disclosure in connection with insurance transactions.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by notifying the Plan Sponsor and/or the Company in the Liberty Mutual group of companies to which I submit a claim.

Print Name

Date of Birth

Signature

Date