



Underwriting Company (herein referred to as the "Company"): \*

- CNA Group Life Assurance Company
- Continental Casualty Company

# LTD EMPLOYEE'S STATEMENT

For assistance call: 1-800-303-9744

Company Name
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**Use back to answer any questions where space does not permit. Return form to Employer.**

Name (Last, first, middle initial)	Telephone No. (Include Area Code)	Date of Birth
Home Address (Street number, city, state, zip code)		Social Security Number

Mailing Address, if different from Home Address (Street number, city, state, zip code)

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	If married, Spouse's Name & Birth Date	Number of Dependent Children:	Birth Date of Youngest Dependent:
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Have you applied for or are you receiving benefits from:	Applied		Receiving		Date Applied For	Amount Received		Effective Date	Paid Thru Date
	Yes	No	Yes	No		Weekly	Monthly		
a. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
c. State Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
d. Retirement or Pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
e. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**\*Please Attach copies of letters or notices related to these Other Benefits**

If due to injury, how and when did this accident occur?	Date first treated for this sickness or injury:
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How does sickness/injury prevent you from returning to work?	Date last worked prior to current sickness/injury:	On what date were you able to or do you expect to return to work?
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**List primary physicians you consulted because of this disability. (Use other side if necessary)**

Physician's Name	Address & Phone No. (Including Area Code)	Dates Treated
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

\*\*\*CONTINUED ON PAGE 2 – BE SURE TO SIGN\*\*\*

**List all hospital confinements for this disability. (Use other side if necessary)**

Name of Hospital	Address	Date Confined
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

\* Unless indicated otherwise above, the underwriting company will be CNA Group Life Assurance Company. If CNA Group Life Assurance Company is not authorized to issue coverage in connection with the above policy, then coverage will be provided by Continental Casualty Company.

**\*\*IMPORTANT NOTICE\*\***

**Residents of all states EXCEPT FL, NJ, AZ, & NH:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement 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.

**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.

**NEW JERSEY RESIDENTS:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**ARIZONA RESIDENTS:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**NEW HAMPSHIRE RESIDENTS:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**Important: The following authorization must also be completed by the Employee:**

I authorize any physician, medical professional, hospital, covered entity as defined under Health Insurance Portability and Accountability Act (HIPAA), insurer or other organization or person having any records, dates, or information concerning my occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and alcohol/drug records to release all such records in their entirety to the Company. I understand I may receive a copy of this authorization, and that this authorization is valid for the entire duration of my claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to my employer, regulatory state agency, or my Workers' Compensation carrier. I have read and understand the Important Notice above.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed