



APPLICATION FOR DISABILITY BENEFITS
 (To Avoid Delay, Please Answer All Questions)
 Form Must be Completed in Full
 to Process Benefits



P.O. Box 117086
 Carrollton, Texas 75011-7086
 Phone: (972) 512-5600 Fax: (972) 512-5828
 Toll Free: (866) 791-9080
 E-mail : HSRDisability@hsri.com

Policy Number(s):

PART I – CLAIMANT’S REPORT

| | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------|-----------------------------|-----------|
| 1. Claimant’s Full Name (last, first, middle) | 2. Social Security Number - - | 3. Gender __M __F | 4. Birthday __ / __ / __ | 5. E-Mail |
| 6. Claimant’s Address (street, city, state, zip) and Best Contact Phone Number (include area code) | | | | |
| 7. Occupation | 8. Date of Accident | 9. Place Where Accident Occurred | | |
| 10. Nature of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) | | | | |
| 11. Describe How Accident Occurred – Give Complete Details of this Incident | | | | |
| 12. Date First Treated for this Injury | 13. Name and Address of Physician | | | |
| 14. Have you ever had the same or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Name and Address of Physician | | | |
| I hereby authorize any hospital, physician, or other person who has examined or attended me to disclose when requested to do so, all information with respect to any injury, treatment, policy coverages, medical history, consultations or prescriptions, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. | | | | |
| 16. Signature | | | | 17. Date |

PART II – POLICYHOLDER’S STATEMENT

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------|--------------------|
| 1. Last Day Worked | 2. Occupation at Time of Injury | 3. Basic Monthly Earnings | 4. Monthly Benefit |
| 5. Did Accident Occur During a Policyholder Sponsored and Supervised Activity? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 6. Signature of Policyholder Representative | | 7. Title | 8. Date |

PART III – ATTENDING PHYSICIAN’S STATEMENT

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------|----------|----------------------------------------------------------------------------------------------------------------------------------|----------|
| 1. Diagnosis and Concurrent Conditions use ICD-9 code(s) or give name(s) | | 2. Is this condition due to injury arising out of patient’s employment? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. Date Symptoms First Appeared | | 4. Date Patient First Consulted You for this Condition | |
| 5. Has Patient ever had Same or Similar Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, when and describe) | | | |
| 6. Name, Address, and Best Contact Phone Number of Referring Physician | | | |
| 7. Is Patient Totally Disabled (unable to work)? If so, indicate the date(s) the patient is totally disabled. | | 8. Is Patient Partially Disabled? If so, indicate the date(s) the patient is partially disabled. | |
| From: | Through: | From: | Through: |
| 9. If Still Disabled, Date Patient Should be Able to Return To Work | | 10. Is Patient Still Under Your Care for this Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. Physician’s Best Contact Phone and Fax Numbers (include area code) and E-Mail Address | | | |
| 12. Physician’s Address (street, city, state, zip) | | | |
| 13. Physician’s Name (Printed) | | 14. Physician’s Signature | |
| | | 15. Date | |

FRAUD STATEMENTS

GENERAL: 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.

ALASKA, ARKANSAS, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

ARIZONA: 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.

CALIFORNIA: 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.

COLORADO: 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.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA RESIDENTS: **WARNING** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: 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.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MARYLAND: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: 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.

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

NEW MEXICO: 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 civil fines and criminal penalties.

NEW YORK: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

PENNSYLVANIA: 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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

TEXAS: 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.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.