



EMPLOYEE REQUEST FOR INFORMATION

Aetna Life Insurance Company
Telephone **866-282-8495**
Fax **877-693-7258**

This notice should be completed and mailed to Aetna Life Insurance Company in order to initiate a disability claim. Complete and sign the request using BLUE or BLACK ink.

EMPLOYER INFORMATION (To be completed by the Employer.)						
Employer's Name				EIN Number		
Employer's Address: Street			City	State	Zip	
Work Location (if different from the above)						
Supervisor's name and telephone number						
Does member have both Aetna Disability and Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Aetna Disability Control Number	Disability Suffix	Disability Account	STD	LTD	Disability Plan
Complete all applicable information.	Aetna Health Plan Control Number	Health Plan Suffix	Health Plan Account	Health Plan Summary Code		
Employee's Name (Last, First, Middle Initial)			Employee Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Employee's Social Security Number	
Date of Hire (MM/DD/YYYY)	STD Coverage Effective Date (MM/DD/YYYY)	LTD Coverage Effective Date (MM/DD/YYYY)	Date Last Worked (MM/DD/YYYY)	Was more than a half day completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employee's Occupation		Occupation is: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	Date Salary continuation was paid through (MM/DD/YYYY)	Reason employee ceased work		
Employee's earnings are: \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly				Number of hours per week		
If premium deductions are to be withheld please list the amounts (weekly)			The portion of the cost of coverage that is paid by the employee with post-tax dollars is non-taxable. What percentage of the cost of coverage is paid by the employee in this manner?			
	Amount	Pre-tax \$	Post-tax			
Medical	\$ _____	_____ %	_____ %	STD _____% LTD _____%		
Life	\$ _____	_____ %	_____ %			
Other	\$ _____	_____ %	_____ %			
The following is applicable only if the employee also has group life insurance with Aetna:						
Amount of Life Insurance Coverage Basic \$ _____ Supplemental \$ _____			Type of Disability Coverage included with Life insurance <input type="checkbox"/> DBO-AID <input type="checkbox"/> PTD <input type="checkbox"/> Premium Waiver <input type="checkbox"/> SIB-PW			
Name and phone number of person providing the above information:				Date (MM/DD YYYY):		
EMPLOYEE INFORMATION (To be completed by the Employee.)						
Employee's Address: Street			City	State	Zip	
Telephone number		May we leave messages on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of birth (MM/DD/YYYY)	
Date first missed work due to disability (MM/DD/YYYY)			Date returned/will return to work (MM/DD/YYYY)			
What is the nature of your disability (diagnosis and/or ICD/CPT Code)?			Were you hospitalized due to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what date were you hospitalized on?			
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this condition the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this condition the result of a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What is your occupation?		Briefly describe your job duties				
What is your doctor's name?		What is your doctor's address and phone number?				
Has your doctor recommended that you stay out of work because you cannot perform your job at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long do they expect you to remain out of work?						
Briefly describe how your condition prevents you from working						
Have you been disabled as a result of this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and how long?			Are you receiving any other form of income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe			
By furnishing this blank and investigating the claim, Aetna shall not be held to admit the validity of any claim or waive the breach of any condition of the policy or contract. For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. Attention Colorado Residents: Any insurer or agent who knowingly provides false or misleading information must be reported to the Insurance Division.						
Employee Signature _____				Date (MM/DD/YYYY) _____		

Mail this completed form to: **Aetna Life Insurance Company**
P.O. Box 14552
Lexington, KY 40512-4552