



# EMPLOYEE REQUEST FOR INFORMATION

Aetna Life Insurance Company  
Phone 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. Neither the furnishing of this form, nor its acceptance by the company, shall be construed as an admission of liability or a waiver of any of the provisions of the plan document.

EMPLOYER INFORMATION				
Name of Employer				EIN#
Employer Address				
Work Location (if different from the above)				
Supervisor's name and phone number				
Control #	Suffix	Account	STD Plan	LTD Plan
Employee's Name				Employee's SS#
Date of Hire	STD Coverage Effective Date	LTD Coverage Effective Date	Date Last Worked	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		Salary continuation was paid through (date)
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) Medical \$      Life \$      Other \$		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? STD    %    LTD    %		
The following is applicable only if the employee also has group life insurance with Aetna:				
Amount of Life Insurance Coverage		Type of Disability Coverage included with Life insurance		
Basic	\$ _____	<input type="checkbox"/> DBO-AID	<input type="checkbox"/> PTD	
Supplemental	\$ _____	<input type="checkbox"/> SIB-PW	<input type="checkbox"/> Premium Waiver	
Name and phone number of person providing the above information:				Date:
EMPLOYEE INFORMATION				
Employee's Address				
Phone number		May we leave messages on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of birth
Date of Hire	Date Last Worked	Date first missed work due to disability		Date returned/will return to work
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 so, 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 so, when and how long?		Is there any other information you would like to add/we should be aware of		

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 \_\_\_\_\_

Mail this completed form to: Aetna Disability Services  
Disability Claim Intake  
P.O. Box 1460  
Portland, OR 97207