

We are sorry that the insured has experienced an unexpected change in their health. We recognize how difficult this can be and we are here to help during the claim process.

The following information describes key requirements and steps in the Disability Insurance claim process. If the insured has both Disability Insurance and Life Insurance policies with a waiver of premium provision, we will assess them collectively. Please read this carefully before you begin and keep it for future reference.

If you have any questions or need help completing the forms, contact Client Services at 800-748-9493, extension 6610229. We're happy to assist you.

CLAIM REQUIREMENTS

Enclosed you will find the forms that need to be completed to file a claim as well as a checklist of requested forms. While all requested information is needed for a decision to be made, we will begin the claim review upon receipt of the Disability Benefits Claim Form and fully executed Authorization(s). Therefore, we recommend the insured provides these documents as soon as they are completed and return any remaining requirements as soon as possible to help expedite the review process.

We may request additional documentation and/or information as needed to ensure that we have a complete and accurate understanding of the insured's disability claim. Northwestern Mutual's claim decision is based on a variety of information, including medical, occupational, and financial evidence, as well as the terms of the insured's contract(s).

If any of the insured's medical providers request a special authorization to release medical records, you may be contacted by vendors contracted by Northwestern Mutual to assist us in obtaining that information.

COMMUNICATION

Once the insured's claim forms have been received, you can expect to hear from the claim analyst within 7 business days.

Throughout the claim review process, you may be contacted by the analyst, a Northwestern Mutual field claim consultant, or an outside representative retained by Northwestern Mutual to provide updated status reports about the insured's claim and/or to gather additional claim related information. This contact may be by phone, mail or by a personal appointment setup at your convenience.

BENEFIT PAYMENTS

Benefits for approved claims begin to accrue on the Beginning Date that the insured selected when the policy was purchased and are payable at the end of each 30-day interval. The Beginning Date can be found on page 3 of the insured's policy.

An Example of a Policy With a 91-Day Beginning Date:	
If the onset of disability was	May 6
A 91-day Beginning Date would be met	August 4
The first benefit payment date would be	September 4

WAIVER OF PREMIUM BENEFIT AND/OR WAIVER BENEFIT

It is important to continue paying the policy premiums while the insured's claim is pending.

For Disability Policies:

Premiums will be waived for policies that are approved if an insured's disability lasts:

- For at least 90 days, or
- Beyond the Beginning Date, whichever is sooner.

For Life Policies with the Waiver of Premium Benefit or Waiver Benefit:

Premiums will be waived for policies that are approved if:

- The insured becomes totally disabled while this benefit is in force;
- The total disability results from an accident or sickness; and,
- The total disability lasts for at least six consecutive months.

If the insured's claim is approved, premiums will continue to be waived as long as the insured qualifies for benefits in accordance with their contract(s).

Please refer to the actual contract(s) for complete policy provisions.

ONGOING CLAIM REQUIREMENTS

IMPORTANT: To continue receiving benefits on an approved claim, you will periodically be asked to provide updated documentation and/or information as outlined in the insured's policies. Forms will be sent to you for completion and must be returned to us by the due date indicated on the forms. Failure to provide completed forms and other requested information in a timely manner may delay or suspend the insured's benefit payments in accordance with their contract provisions.

At Northwestern Mutual we understand that this may be a difficult time for the insured, and we are committed to providing assistance during the claim process.

For your convenience, below is a checklist of enclosed forms and documents needed to start the claim evaluation process. While all the information below is needed to evaluate the insured's claim, the claim will be assigned to an analyst to begin the review process upon receipt of the Disability Benefits Claim Form and fully executed Authorization(s).

The insured's information will be kept confidential according to our privacy policy.

ENCLOSED FORMS

☐ **Disability Benefits Claim Form**

Complete all the information requested on this form. Incomplete information may delay the evaluation and potential payment of the insured's claim.

☐ **Authorization (2 copies)**

- Review, sign, date, and provide the insured's complete address on all Authorizations.
- Return one Authorization to Northwestern Mutual.
- Send one Authorization to the insured's physician with the Attending Physician's Statement. If the insured has multiple physicians, please make additional copies to send with each request.
- We recommend making a copy of this Authorization for the insured's records.

☐ **Attending Physician's Statement (2 copies)**

Provide one form, along with a signed Authorization (referenced above), to each physician who has treated the insured during the period(s) the insured is claiming benefits.

- Medical treatment supporting the insured's requested disability must span the entire period being claimed.
- Refer to the instructions at the top of the Attending Physician's Statement regarding any fees charged by the insured's physician.
- If the insured has more than two physicians, please make additional copies.

☐ **Authorization to Discuss Claim Information (Optional)**

Complete this form if you would like to authorize us to discuss the insured's claim with their financial representative or another person, such as their spouse. Indicate the specific type of information we can discuss with each individual.

The following additional forms may also be enclosed:

☐ **Authorization for the Release of Psychotherapy Notes (2 copies)**

If the insured's claim is the result of a psychiatric condition, we have enclosed this authorization. If this form is not enclosed, it may be requested at a later date.

- Review, sign, date, and provide the insured's complete address on all Authorizations.
- Return one Authorization to Northwestern Mutual.
- Send one Authorization to the insured's physician with the Attending Physician's Statement. If the insured has multiple physicians, please make additional copies to send with each request.
- We recommend making a copy of this Authorization for the insured's records.

☐ **Substitute Form W-9**

If the insured has a Disability Overhead Expense policy, this form has been included.

- Enter the Taxpayer Identification Number for the owner of the policy.
- Review, sign, and date this form.
- Return this form to Northwestern Mutual.

☐ **Participation Agreement for Deferred Disability Benefit Trust**

If the insured's policy has the Deferred Disability Benefit, a separate explanation letter is enclosed along with a Participation Agreement and instructions.

FINANCIAL DOCUMENTATION

Please provide the following federal income tax returns as filed with the IRS (including any amended returns) for:

- three consecutive years prior to the insured's requested onset date of disability
- every year during the insured's claimed disability
- business owner: include personal and business returns

Personal income tax information:

- ☐ Form 1040 and all schedules and statements
- ☐ W-2(s) supporting all income reported on Form 1040 (including spousal W-2 if applicable)
- ☐ 1099 forms
- ☐ Year-end pay stubs (to verify deferrals made for pre-tax health and retirement benefits)

Business tax returns for all entities in which you have an ownership interest:

Partnership, LLC or LLP

- ☐ Schedule K-1 (Form 1065)

S Corporation

- ☐ Form 1120S and all schedules (be sure to include the K-1) and statements
- ☐ The insured's share of the pension or profit sharing reflected on Form 1120S, Line 17

C Corporation

- ☐ Form 1120 and all schedules and statements
- ☐ List separately the insured share of the pension or profit sharing reflected on Form 1120, Line 23

Additional Financial Information:

After reviewing these financial documents, we will contact you if additional information or documentation is needed.

Claim Checklist **Disability Insurance**

How should I return the completed forms and supporting documentation?	
Preferred Method: Only Available to Policyowner	
Disability Claim Center	Log into your account on NM.com Provides a way for you to access and provide information on your disability insurance claim easily. • Share documents – download, upload and view your documents. • View your claim status – check the status of your claim and get details on recent payments. • Get extra support – have contact information at your fingertips.
Additional Methods	
Fax	(414) 625-1526
Mail	Northwestern Mutual Claims Department PO Box 2918 Milwaukee, WI 53201-2918



Northwestern Mutual®

The Northwestern Mutual Life Insurance Company
720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202

Disability Benefits Claim Form
Disability Insurance

Complete Form in Black or Blue Ink

POLICY NUMBER(S)	CLAIM NUMBER
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Personal Information

NAME

MAILING ADDRESS

CITY

STATE

ZIP CODE

HOME ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)

CITY

STATE

ZIP CODE

DATE OF BIRTH:

MM

DD

YYYY

PREFERRED PHONE NUMBER

ALTERNATE PHONE NUMBER

☐ CELL

☐ HOME

☐ WORK

☐ OTHER

☐ CELL

☐ HOME

☐ WORK

☐ OTHER

PREFERRED METHOD OF WRITTEN COMMUNICATION:

☐ EMAIL

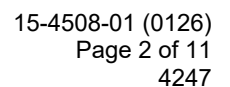
☐ US MAIL

EMAIL ADDRESS



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Information About Your Disability	
Is your disability primarily the result of an ☐ Illness or ☐ Accident/Injury?	
Complete the appropriate section below.	
ILLNESS	
Date symptoms first appeared: <u> </u> / <u> </u> / <u> </u> MM DD YYYY	
Diagnosis:	
Describe your symptoms (including frequency and duration):	
ACCIDENT/INJURY	
Date of accident/injury: <u> </u> / <u> </u> / <u> </u> MM DD YYYY	Was an accident report filed? ☐ Yes ☐ No
Where did the accident/injury occur (include physical location, city, and state)?	
Describe how the accident/injury occurred:	
Describe the injuries you sustained as a result of the accident/injury:	



Disability Benefits Claim Form

Disability Insurance

Medical Provider Information

List all medical providers you treated with or are currently treating with for your claimed disability. This includes, but is not limited to, primary care providers, general practitioners, specialists, physical therapists, physician's assistants, nurse practitioners, psychiatrists, or psychologists. **Attach extra sheet, if necessary.**

PROVIDER NAME	SPECIALTY	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT MM / DD / YYYY	END OF TREATMENT MM / DD / YYYY OR ☐ ONGOING		
PROVIDER NAME	SPECIALTY	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT MM / DD / YYYY	END OF TREATMENT MM / DD / YYYY OR ☐ ONGOING		
PROVIDER NAME	SPECIALTY	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT MM / DD / YYYY	END OF TREATMENT MM / DD / YYYY OR ☐ ONGOING		
PROVIDER NAME	SPECIALTY	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT MM / DD / YYYY	END OF TREATMENT MM / DD / YYYY OR ☐ ONGOING		
PROVIDER NAME	SPECIALTY	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT MM / DD / YYYY	END OF TREATMENT MM / DD / YYYY OR ☐ ONGOING		



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Disability Benefits Claim Form

Disability Insurance

Hospital/Clinic Information

List all hospitalizations or inpatient visits related to your disability. **Attach extra sheet, if necessary.**

HOSPITAL/CLINIC NAME	TYPE OF FACILITY ☐ CLINIC ☐ HOSPITAL	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT ____ / ____ / ____ MM DD YYYY	END OF TREATMENT ____ / ____ / ____ MM DD YYYY	OR ☐ ONGOING	
HOSPITAL/CLINIC NAME	TYPE OF FACILITY ☐ CLINIC ☐ HOSPITAL	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT ____ / ____ / ____ MM DD YYYY	END OF TREATMENT ____ / ____ / ____ MM DD YYYY	OR ☐ ONGOING	
HOSPITAL/CLINIC NAME	TYPE OF FACILITY ☐ CLINIC ☐ HOSPITAL	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
START OF TREATMENT ____ / ____ / ____ MM DD YYYY	END OF TREATMENT ____ / ____ / ____ MM DD YYYY	OR ☐ ONGOING	

Pharmacy Information

Indicate where you fill your prescriptions. (Check all that apply)

- | | | | |
|--|--|--|--|
| ☐ Amazon | ☐ Caremark | ☐ Costco | ☐ CVS/Longs
Drugs/Target |
| ☐ Express Scripts/Medco | ☐ Kaiser Permanente | ☐ Rite Aid | ☐ Sam's Club |
| ☐ Walgreens | ☐ Walmart | ☐ Other: provide pharmacy information below | |

PHARMACY NAME	PHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP CODE
PHARMACY NAME	PHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP CODE



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Disability Benefits Claim Form

Disability Insurance

Employment Information

Were you employed when your disability began?

☐ Yes ☐ No

If no, when did your employment end?

____ / ____ / ____
MM DD YYYY

Why did your employment end?

List your most recent employer(s) below. If you were unemployed at the onset of your requested disability, list the name of your last employer(s) below.

EMPLOYER NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

START OF EMPLOYMENT

END OF EMPLOYMENT

____ / ____ / ____
MM DD YYYY

____ / ____ / ____
MM DD YYYY

OR ☐ ONGOING

EMPLOYER NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

START OF EMPLOYMENT

END OF EMPLOYMENT

____ / ____ / ____
MM DD YYYY

____ / ____ / ____
MM DD YYYY

OR ☐ ONGOING

Has your employer paid any portion of premiums for any disability policy under which you are claiming benefits?

☐ Yes ☐ No If yes, what percentage? ____ %

Are you a business owner? ☐ Yes ☐ No **If no, skip to the Occupation Information section.**

☐ Sole Proprietorship ☐ S Corporation

☐ Partnership/LLC/LLP ☐ C Corporation

BUSINESS NAME

OWNERSHIP %

☐ Sole Proprietorship ☐ S Corporation

☐ Partnership/LLC/LLP ☐ C Corporation

BUSINESS NAME

OWNERSHIP %

Since your disability began, have you or are you planning to:

Change the nature of your business: ☐ Yes ☐ No Sell your business: ☐ Yes ☐ No

Transfer your ownership share of the business: ☐ Yes ☐ No Start a new business: ☐ Yes ☐ No

If yes to any of the above, explain below.



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Disability Benefits Claim Form Disability Insurance

Occupation Information

Provide a detailed list of the essential job duties and responsibilities of your occupation (be specific).

Job Duties PRIOR to Disability Onset	% of time at each duty	Job Duties AFTER Disability Onset	% of time at each duty
Total	100%	Total	100%

Hours Worked PRIOR To Onset of Disability		Hours Worked AFTER Onset of Disability	
HOURS PER DAY	HOURS PER WEEK	HOURS PER DAY	HOURS PER WEEK

Explain how your illness or accident/injury limits you from performing the job duties listed above and/or working the usual hours of your occupation(s):

Describe your daily activities since the onset of your disability, including home, recreational, and social activities (e.g., hobbies, volunteer work, household maintenance, etc.):

Did you have any other jobs or occupations at the time your disability began? ☐ Yes ☐ No

If yes, describe what you were doing and include average hours worked per week:



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Disability Benefits Claim Form Disability Insurance

Periods of Disability Information

When did your illness or accident/injury first limit you from working the substantial and material job duties and/or hours of your occupation(s)?

____ / ____ / ____
MM DD YYYY

Since the above date I have (check all that apply and complete the corresponding section below):

- ☐ Stopped working and have not worked in any capacity in my occupation (Complete Section A)
- ☐ Performed some job duties and/or worked reduced hours in my occupation (Complete Section B)
- ☐ Alternated between not working and working in a reduced capacity in my occupation (Complete Sections A and B)
- ☐ Stopped working in my occupation and worked in a different occupation (Complete Section C)
- ☐ Recovered and/or no ongoing limitations (Complete Section D)

A. Period(s) I did not work:

From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY
From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY
From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY

B. Period(s) I worked in a reduced capacity:

From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY
From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY
From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY

C. Period(s) I worked in a different occupation:

From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY
From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY
From: ____ / ____ / ____ MM DD YYYY	To: ____ / ____ / ____ MM DD YYYY

D. Recovery and/or No Ongoing Limitations Date:

____ / ____ / ____
MM DD YYYY



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Disability Benefits Claim Form

Disability Insurance

Professional License, Certificate, and Liability Information (if applicable)

TYPE OF LICENSE OR CERTIFICATE	ISSUING AUTHORITY	LICENSE OR CERTIFICATE NUMBER
TYPE OF LICENSE OR CERTIFICATE	ISSUING AUTHORITY	LICENSE OR CERTIFICATE NUMBER

Were all your licenses or certificates current at the onset of disability? ☐ Yes ☐ No

If no, explain:

Bankruptcy Information

Are you, or is a business you own, currently involved in or preparing to file for bankruptcy? ☐ Yes ☐ No

If yes, check those that apply:

☐ Chapter 7 (liquidation) ☐ Chapter 11 (reorganization) ☐ Chapter 13 (debt workout)

Date of Filing

____ / ____ / ____ OR ☐ Not Yet Filed
MM DD YYYY

Date of Discharge

____ / ____ / ____
MM DD YYYY

Disability Benefits Claim Form

Disability Insurance

Other Insurance Information

If you have applied for benefits under any of the programs listed below, check the appropriate box. If you are currently receiving benefit payments, provide the effective date.

Attach a copy of the Social Security Award Certificate.

Note: Entitlement to Social Security Benefits does not automatically qualify you for benefits under your Northwestern Mutual policy(ies). Eligibility for Northwestern Mutual benefits is contingent upon receipt of Proof of Disability/Loss as defined in your policy(ies). Please refer to your contract(s) for complete policy provisions.

☐ Social Security Disability

Effective Date: ____ / ____ / ____
MM DD YYYY

☐ Social Security Retirement

Effective Date: ____ / ____ / ____
MM DD YYYY

☐ State Disability (CA, HI, NJ, NY, Puerto Rico, and RI)

Effective Date: ____ / ____ / ____
MM DD YYYY

Are you covered under a Northwestern Mutual Group Disability Policy? ☐ Yes ☐ No

If yes, provide employer name and policy number below.

EMPLOYER NAME

POLICY NUMBER

If you have applied for or are receiving benefits under any of the following, provide details below:

- Individual Disability
- Life Insurance Waiver of Premium
- VA Disability
- Group Disability
- Worker's Compensation
- Other
- Disability Overhead Expense
- Unemployment Compensation

Attach extra sheet, if necessary.

TYPE OF POLICY OR BENEFIT	INSURANCE CARRIER	POLICY NUMBER
BENEFIT AMOUNT	PHONE NUMBER	☐ Applied for benefits ☐ Currently receiving benefits
TYPE OF POLICY OR BENEFIT	INSURANCE CARRIER	POLICY NUMBER
BENEFIT AMOUNT	PHONE NUMBER	☐ Applied for benefits ☐ Currently receiving benefits
TYPE OF POLICY OR BENEFIT	INSURANCE CARRIER	POLICY NUMBER
BENEFIT AMOUNT	PHONE NUMBER	☐ Applied for benefits ☐ Currently receiving benefits



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Disability Benefits Claim Form

Disability Insurance

Signature

By signing below, I agree to the statements contained in this Disability Benefits Claim form, and I declare that all of the answers and amounts reflected above and on any attached financial or tax statements are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof. Proof for the purpose of this policy includes (but is not limited to) medical documentation, earned income and expenses, confirmation of occupation/job duties and full details of other insurance.

For your protection some states require us to inform you that any person who knowingly or willfully files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending on the state. Such actions may be deemed a felony and substantial penalties may be imposed.

For CA and Other States Residents: In California and other states, any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For NH 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.

For NY Residents: 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.

DATE SIGNED: _____

SIGNATURE OF INSURED OR LEGAL REPRESENTATIVE

MM

DD

YYYY

For legal representative, please provide a copy of the legal document granting your legal authority and complete below.

PRINT NAME/TITLE OF LEGAL REPRESENTATIVE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

Disability Benefits Claim Form

Disability Insurance

How should I return the completed claim form and supporting documentation?

Preferred Method: Only Available to Policyowner

Disability Claim Center

To access the Disability Claim Center, log into your account on NM.com
Disability Claim Center provides an easier way to access and submit information on your disability insurance claim. You can:

- Share documents – download, upload, and view your documents.
- View your claim status – check the status of your claim and get details on recent payments.
- Get extra support – have contact information at your fingertips.

Additional Methods

Fax

(414) 625-1526

Mail

Northwestern Mutual
Claims Department PO Box 2918
Milwaukee, WI 53201-2918



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