ACCIDENT AND SICKNESS INSURANCE

PART I

DESCRIPTION OF POLICY

Purpose

An Accident and Sickness policy provides benefits for absence from work due to total disability.

Terms

1. The Employee must be insured for Accident and Sickness benefits.

2. While so insured, the Employee must become wholly and continuously disabled by an injury or sickness so as to be prevented from performing any and every duty of his occupation.

3. During such a period of disability, the Employee must receive treatment from a physician legally licensed to practice medicine.

Provisions

1. Benefits will be paid to the Employee each week during any period of disability for which benefits are payable.

2. The amount of benefits payable each week during such a period of disability is the amount of benefits in force on account of the Employee on the date the disability commences.

3. The Company has the right and opportunity to have a physician designated by it examine the person of the Employee when and so often as it may reasonably require while benefits are being claimed.

4. An Employee's Accident and Sickness insurance automatically ceases on whichever of the following dates first occurs: (1) the date of termination of the Employee's employment; (2) the date of expiration of the maximum number of weeks for which benefits are payable on account of the Employee's disability; (3) the date of expiration of the last period for which contributions to the cost of his insurance were made by the Employee, in case he fails to make a contribution required by the policyholder; (4) the date of cancelation of the policyholder's Group Insurance Plan; or (5) the date of cancelation of the policyholder's Accident and Sickness insurance policy.

5. An Employee's Accident and Sickness insurance, if canceled by payment of the maximum number of weeks of benefits he is entitled to receive for a period of disability, may be reinstated if and when he returns to active work for the policyholder on a full-time basis.

6. The cancelation of an Employee's Accident and Sickness insurance does not affect consideration of any claim incurred before such cancelation.

Limitations

1. Not more than (13) weeks' benefits are payable for any one continuous period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

2. Not more than six weeks' benefits are payable for disability caused by any one pregnancy or resulting childbirth or complications.

Exclusions

1. No benefits are payable for a period of disability due to an injury arising out of or in the course of any employment for wage or profit.

2. No benefits are payable for a period of disability due to a sickness entitling the Employee to benefits under any Workmen's Compensation or Occupational Disease Law.

3. No benefits are payable for the first (seven) days of total disability.

5. An Employee's Accident and Sickness insurance, if canceled by payment of the maximum number of weeks of benefits he is entitled to receive for a period of disability, may be reinstated if and when he returns to active work for the policyholder on a full-time basis.

6. The cancelation of an Employee's Accident and Sickness insurance does not affect consideration of any claim incurred before such cancelation.

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PART II

HELPFUL POINTERS

ESSENTIAL PAYMENT INFORMATION

The current edition of Form G.H. 24-C requests more than 25 separate items of information. Some of these items of information are necessary to identify a claim as to the Employee and the policyholder involved. Many of these items of information are merely helpful in evaluating a claim. Six of them, however, are essential to the payment of any claim for Accident and Sickness benefits. These six items of essential payment information are:

1. The amount of the Employee's Weekly Benefit.
2. The effective (issue) date of the Employee's Weekly Benefit.
3. The date the Employee last worked prior to the onset of total disability.
4. The nature of the Employee's sickness or injury (a diagnosis by his attending physician of the condition or conditions causing total disability).
5. The dates on which the Employee received treatment.
6. The dates of total disability (the period during which the Employee was continuously disabled and unable to work).

If the Employee's Weekly Benefit rate is not shown on a claim form, the claim should be paid at the Weekly Benefit rate shown on his previous claim. If no previous claim is available, and the policyholder's accounting system is "simplified," the current claim should be paid at the lowest benefit rate shown on the policyholder's Work Sheet. In either instance, Form 11757, a printed form letter prepared by the Claim Payment Typists, should be mailed to the policyholder. This letter explains the Weekly Benefit rate at which the claim has been paid and requests notification of the Employee's correct Weekly Benefit rate if the payment of the claim has to be adjusted. (If the policyholder's accounting system is "non-simplified," the Employee's Weekly Benefit rate should be obtained from the appropriate Record Section of the Group Administration Division by means of a telephone call or a Data Slip.)

If the effective date of the Employee's Weekly Benefit rate is not shown on a claim form, it should be obtained from his previous claim. If no previous claim is available, and the policyholder's accounting system is "simplified," the current claim may be paid, but CG letter 403 should be mailed to the policyholder. This letter requests the policyholder, before releasing the check issued in payment of the claim, to make certain that the Employee's insurance was properly in force at the time the claim was incurred. (If the policyholder's accounting system is "non-simplified," the effective date of

the Employee's Weekly Benefit rate should be obtained from the Group Administration Division.)

If the date the Employee last worked before becoming totally disabled is not shown on a claim form, it should be requested by means of a dictated letter before the claim is considered for payment.

If the attending physician's report does not include a diagnosis of the Employee's disability, it is necessary to request, before the claim is considered for payment, that the Employee obtain from the attending physician a statement giving a complete diagnosis of the condition or conditions causing total disability, including complications, if any - unless this information is given on another claim, such as a claim for Hospital Expense benefits. (NOTE: All requests for information to be obtained from an attending physician should make it clear that the Employee, not the policyholder, is to obtain the information.)

If the attending physician's report does not show any dates of treatment, the claim should not be considered for payment; instead, Form 11762, a printed form letter prepared by the Claim Payment Typists, should be mailed to the policyholder.

If the attending physician's report does not show the dates of total disability, the claim should not be considered for payment; instead, Form 11762 should be mailed to the policyholder.

As indicated above, Form 11762 can be used to request either or both of two items of essential payment information: the dates of treatment and the dates of total disability. Any other combination of items of essential payment information that are omitted from a claim form must, however, be requested or explained by means of a dictated letter.

Of the six items of essential payment information discussed above, the policyholder is required to furnish three: the amount of an Employee's Weekly benefit, the effective date of this benefit, and the date the Employee last worked prior to the onset of total disability. If these three essential items of information are omitted from the Employer's section of a claim form, or if the Employer's section of a claim form is not completed at all, the claim form should be returned to the policyholder with Form 11756 after a photostatic copy of both sides of the claim form has been made. Form 11756 requests completion of the Employer's section of the claim form.

ACCEPTABLE PHYSICIANS

Although Accident and Sickness policies indicate that an Employee must be treated by a "physician legally licensed to practice medicine," benefits are payable for total disability certified by a licensed practitioner of any of the recognized healing arts.

Accordingly, benefits are payable not only for total disability certified by a Doctor of Medicine (M.D.), but also for total disability certified by an osteopath (Doctor of Osteopathy - D.O.), a chiropractor (Doctor of Chiropractic - D.C.), a chiropodist (Doctor of Surgical Chiropody - D.S.C.; also called a podiatrist: Doctor of Podiatry - Pod. D.), or a dentist (either a Doctor of Dental Surgery - D.D.S., or a Doctor of Dental Medicine - D.D.M.).

A claim showing treatment by any other type of practitioner - a naprapath, a mechanotherapist, or a naturopath, for example - should be referred to a Senior Claims Approver for instructions as to its disposition.

CHRISTIAN SCIENCE TREATMENT

Although a Christian Science practitioner (C.S.) is not a licensed physician, a statement by a Christian Science practitioner that an Employee was unable to attend to his regular duties during a period of Christian Science treatment is acceptable as evidence of total disability. In such cases, however, it is usual to institute a mercantile agency investigation of the Employee's activities, to verify or to establish the existence, cause, or duration of total disability.

Any claim for Accident and Sickness benefits showing treatment by a Christian Science practitioner should be referred upon receipt to a Senior Claims Approver; every such claim is given individual consideration.

TOTAL DISABILITY REQUIREMENT

The principal requirement of Accident and Sickness policies is that an Employee become "wholly and continuously disabled so as to be prevented from performing any and every duty of his occupation." On the basis of this requirement, a claim should be declined for payment if it shows that an Employee was merely partially disabled - that is, that he was able to perform any duty of his occupation while continuing to work on a part-time basis.

A claim should also be declined for payment if it involves a period of disability that commenced prior to the date the Employee's Accident and Sickness insurance was issued, since Accident and Sickness policies also require that an Employee become totally disabled "while insured for Accident and Health Insurance." This requirement also means that no benefits are payable for any period of total disability which commences after the date an Employee's Accident and Sickness insurance is canceled.

A period of total disability is identified by an attending physician on an Accident and Sickness claim form in terms of the dates of the inclusive period during which "The patient has been continuously disabled (unable to work)." In no case are the dates of an Employee's period of absence from

work, as furnished by a policyholder, to be considered as the dates of a period of total disability - a period of total disability can begin one or more days after an Employee's last day at work, and can end one or more days before the date he returns to work.

THREE-HOUR RULE

The "three-hour rule" is an administrative ruling which provides that any day on which an Employee works less than three hours may be considered a day of total disability.

This important ruling therefore means that benefits are payable for any day on which an Employee works less than three hours, provided that any such day is claimed as a day of disability by the Employee or is certified as such by his attending physician.

Conversely, this ruling means that no benefits are payable for any day on which an Employee works three hours or more, even if the attending physician certifies that the Employee was totally disabled on the date involved.

Benefits can be paid in accordance with the "three-hour rule" only if a policyholder specifies that an Employee worked less than three hours on a given date. Accordingly, benefits may be paid for any day on which, for example, the Employee "worked 2½ hours." On the other hand, a statement by a policyholder that an Employee "went home at 11:30 a.m." on a given date is not acceptable as evidence that the Employee worked less than three hours on that date - the Employee may have begun work at 7:00 a.m. or 8:00 a.m. instead of at or after 9:00 a.m. Similarly, no benefits are payable for any day on which a Employee works "half a day" or leaves work at or after 12 o'clock noon.

In cases showing that the Employee resumed work on a part-time basis, it is to be assumed that the Employee's daily schedule of part-time work exceeds three hours. Accordingly, benefits in such cases are to be paid only to the date the Employee resumes work on a part-time basis.

It is not necessary to explain to a policyholder that benefits have been paid, excluded, or terminated on the basis of the "three-hour rule," since it is our practice not to disseminate any administrative ruling ("house rule"). For this reason, any request from a policyholder for an explanation of a claim payment based on the "three-hour rule" should be referred to a Senior Claims Approver for review.

FIRST DAY OF DISABILITY

The first day of a period of total disability is determined by applying one of two administrative rulings. The first of these rulings pertains to claims based on an injury, and the second pertains to claims based on a sickness.

The ruling that is used to determine the first day of a period of disability due to an injury takes into account the fact that an Employee is requested to furnish on a claim form the time and date as well as other details of an accident. This ruling is as follows:

1. If the accident occurs before 12 o'clock noon, the date of the accident is to be accepted as the first day of disability, unless the Employee indicates that he first became disabled on a later date.

2. If the accident occurs after (or at) 12 o'clock noon, the day following the date of the accident is to be accepted as the first day of disability, even if the Employee indicates that he first became disabled on the date of the accident.

If an Employee furnishes the date but not the time of an accident, it is to be assumed that the accident occurred after 12 o'clock noon on the date given; in such cases, the day following the date of the accident is to be accepted as the first day of disability. If the Employee does not furnish the date of an accident, it should be requested before the claim is considered for payment.

The ruling that is used to determine the first day of a period of disability due to a sickness takes into account the fact that an Employee is permitted to indicate on a claim form the date he first became disabled (by either a sickness or an injury). This ruling is as follows:

1. The date on which the Employee claims he first became disabled is to be accepted as the first day of total disability, even if it is several days prior or subsequent to the first day of total disability furnished by the attending physician.

2. If the Employee does not indicate the date he first became disabled, the first day of disability furnished by the attending physician is to be accepted as the first day of total disability.

3. If neither the Employee nor the attending physician furnishes the first day of total disability, but the attending physician's report shows that the Employee underwent a surgical operation or received treatment in a hospital, the date of the operation or the first date of hospital treatment, whichever is earlier, is to be accepted as the first day of total disability.

In all cases the date accepted as the first day of disability must be subsequent to the Employee's last day at work. The first day of disability as furnished by the Employee or the attending physician must be advanced one day if it is also the day the Employee last worked - unless the Employee worked less than three hours on his last day at work. If the policyholder fails to furnish the Employee's last day at work, it should be requested before the claim is considered for payment.

It is not necessary to explain to a policyholder the date accepted as the first day of disability on the basis of either of the two administrative rulings discussed above.

It is important to note that these rulings apply only to a disability that is nonoccupational in origin or is otherwise compensable as such - they are not to be applied when Supplementary Occupational Benefits are paid for an injury or a sickness that is occupational in origin.

It was stated above that the date the Employee claims he first became disabled may be accepted as the first day of disability even if this date is several days prior or subsequent to the date furnished by the attending physician as the first day of disability. On the basis of a "house rule," however, the date furnished by the attending physician is to be accepted as the first day of disability if it is more than seven days subsequent to the date claimed by Employee as the first day of disability. A claim payment resulting from the application of this "house rule" should be explained to the policyholder by check letter. Such a letter should state "The payment of (Mr. Smith's) claim is based on the acceptance of (June 10th) as the first day of total disability, in accordance with information given in the attending physician's report. If (Mr. Smith) first became totally disabled prior to this date, he should have the attending physician complete a statement certifying to such earlier disability. Upon receipt of such a statement, we shall be pleased to consider an adjusted payment of (Mr. Smith's) claim."

WAITING PERIOD

Most Accident and Sickness policies exclude payment for the first three or for the first seven days of a period of disability due to a sickness or an injury. Such policies stipulate that "In no case shall such Weekly Benefits be payable for the first (seven) days of disability." The number of days of disability mentioned in this exclusion comprises what is called a waiting period. A policy which excludes payment for the first seven days of a period of disability is said to contain a waiting period of seven days, and one which excludes payment for the first three days of a period of disability is said to contain a waiting period of three days. The first day of a waiting period is the first day of total disability.

The waiting period of some policies applies only to a period of disability that is due to a sickness. Such policies stipulate that "In no case shall such Weekly Benefits be payable for the first (seven) days of disability due to sickness." Because it mentions only disability due to sickness, this exclusion does not apply to a period of disability due to an injury; it therefore permits benefits to be paid from the first day of a period of disability due to an injury. A policy that imposes no waiting period for a period of disability due to an injury is said to contain the "first day injury" provision. As indicated by the wording of the exclusion just quoted, however, this provision is usually implied rather than expressed. Although it permits the payment of benefits beginning with the first day of a period of disability due to an injury, the "first-day injury" provision in no way affects the choice of

the first day of such a period of disability; the choice of this day depends upon whether the injury is sustained before or after 12 o'clock noon.

As indicated by the wording of the two exclusions quoted above, the days of disability comprising a waiting period need not be consecutive - they can be intermittent. On the basis of an administrative ruling, intermittent days of total disability may be used as days of a waiting period, but only if they are accumulated within a consecutive period that is twice the duration of the waiting period. This ruling therefore requires that any seven days of intermittent disability that are used as a waiting period of seven days must be accumulated within a period of 14 consecutive days; as it applies to a three-day waiting period, this ruling requires that three days of intermittent disability must be accumulated within a period of six consecutive days. The most important point to remember in considering for payment any claim that is subject to this ruling is that the attending physician must indicate that the Employee was totally disabled on each day used as a day of a waiting period.

The "first-day hospital" provision can serve to shorten a waiting period; a "date of medical" payment lengthens a waiting period; the "retroactive" provision waives a waiting period; a waiting period also is waived if a claim is approved for payment as a recurrent claim. Each of these points is discussed in detail in subsequent sections.

The exclusion which establishes the waiting period of an Accident and Sickness policy is the basis of a declination situation: "Period of disability too short." This declination situation would be exemplified by a claim involving only six days of disability that is filed under a policy which excludes payment for the first seven days of disability.

BENEFIT DUE DATE

The benefit due date is the date as of which benefits become due and payable; it is the date following the date on which the waiting period expires.

Accordingly, the benefit due date of a claim subject to a three-day waiting period would be the fourth day of disability, and the benefit due date of a claim subject to a seven-day waiting period would be the eighth day of disability. The benefit due date of an injury claim that is filed under a policy containing the "first-day injury" provision is, of course, the first day of disability. The application of any other provision or payment procedure which serves to modify the duration of a waiting period - for example, the "first-day hospital" provision or a "date of medical" payment - also affects the date on which benefits become due and payable.

DATE OF MEDICAL PAYMENTS

Benefits are payable from the benefit due date only if the Employee receives treatment on or before the eighth day of disability. If the first treatment an Employee receives during disability is rendered more than eight days after the date he becomes totally disabled, benefits are paid beginning with the date of the first treatment, and no waiting period is charged. Such a payment is called a "date of medical" payment.

To detail the circumstances that require a "date of medical" payment, let us assume that a sickness claim submitted under a policy having a seven-day waiting period shows that an Employee became totally disabled on May 4th and returned to work on May 25th. Now let us assume that the attending physician's report states that the Employee was first treated on May 13th. Because the Employee's policy imposes a waiting period of seven days, benefits in this case would ordinarily become due and payable on May 11th, the eighth day of total disability; because the Employee did not receive treatment on or before the eighth day of disability, however, benefits in this case become payable on May 13th, the date the Employee first received treatment during disability.

Because it reduces the amount of benefits otherwise payable for a period of total disability, a "date of medical" payment must be explained to the policyholder. The second paragraph of Form G.863, a printed form letter prepared by the Claim Payment Typists, is used for this purpose. To indicate that a "date of medical" payment is to be explained to the policyholder, it is necessary to note the Work Sheet to that effect. Below is the notation that would appear on a Work Sheet to indicate that the case discussed above was paid on a "date of medical" basis (the letters "DM" stand for "date of medical"):

"Pay 5/4 DM 5/13 and explain"

If a physician's report submitted in response to a "date of medical" letter indicates that the Employee did receive treatment on or before the eighth day of disability, it is necessary to pay benefits for the period of disability initially excluded from payment by the "date of medical" payment. Accordingly, if the Employee in the case mentioned above submitted a medical report stating that he actually had first received treatment on any of the first eight days of his period of disability, it would be necessary to pay two days' additional benefits, for his disability on May 11th and 12th.

It should be remembered that the duration of a waiting period has no effect on a "date of medical" payment - the only factor that determines whether a claim based on an injury, a sickness, or a complication of pregnancy is paid on a "date of medical" basis is whether the Employee first receives medical, hospital, or surgical treatment on any one of the first eight days of disability. As it applies to a three-day waiting period, this important point means that benefits are payable from the fourth day of disability even if an Employee first receives treatment as late as the eighth day of disability.

SUSPENSION OF BENEFITS

Arrangements have been made with a few policyholders to suspend the payment of benefits as of the date immediately preceding an estimated date of return to work furnished by an attending physician. Under this arrangement, the payment of benefits would be suspended as of April 7th if an attending physician's report indicated that an Employee was expected to return to work on April 8th. With other policyholders, arrangements have been made to suspend the payment of benefits as of the Saturday preceding an estimated date of return to work. If either of these two special arrangements for suspending the payment of benefits applies to Accident and Sickness claims of a given policyholder, the Work Sheet prepared for the policyholder will be noted accordingly.

In the absence of such a notation on a Work Sheet, the payment of benefits is to be suspended as of the Sunday preceding an estimated date of return to work furnished by an attending physician. Accordingly, if an attending physician's report indicates that an Employee should be able to return to work on May 7th, a Thursday, the payment of benefits should be suspended as of the preceding Sunday, May 3d. This standard practice of suspending the payment of benefits as of the Sunday preceding an estimated date of return to work applies even if the estimated date of return to work falls on a Saturday or a Sunday. Accordingly, if an attending physician's report indicates that an Employee should be able to return to work on May 9th, a Saturday, or on May 10th, a Sunday, the payment of benefits would be suspended in either case as of the preceding Sunday, May 3d.

The third paragraph of Form G.863, a printed form letter prepared by the Claim Payment Typists, is used to notify a policyholder of a suspension of benefits based on an attending physician's report and reflecting either of the two special arrangements or the standard practice mentioned above. To initiate the preparation of this letter, the word "suspend" and a numerical representation of the date as of which the suspension of benefits is to become effective should be written on the Work Sheet attached to the claim. Below is an example of the notation that should appear on a Work Sheet as an indication to the Claim Payment Typists that a policyholder is to be notified of a suspension of benefits that is to become effective as of July 26th (in this example, July 7th is the first day of disability):

"Pay 7/7 and suspend 7/26."

If an attending physician's report does not furnish an estimated date of return to work, it is necessary to estimate the probable duration of total disability - and to suspend the payment of benefits accordingly - on the basis of such factors as the cause of disability, the nature and the date of any surgical procedure performed or contemplated, the number and frequency of treatments, the duration of any hospital confinement, and the age and sex of the Employee. In these "no prognosis" cases, as they are called, it is best to pay no more than three weeks' benefits unless the

condition involved is one that can result in a long-term disability. Examples of conditions of this type are heart disease, arthritis, hypertension, arteriosclerosis, cerebral hemorrhage, cancer, and tuberculosis.

Form G.1762, a printed form letter prepared by the Claim Payment Typists, is used to notify a policyholder of a suspension of benefits that is based on an estimate of the probable duration of total disability in the absence of an estimated date of return to work furnished by an attending physician. This second type of suspension of benefits is called a "117" suspension of benefits because Form G.1762 explains that the payment of benefits will be suspended as of the date total disability is expected to terminate if a completed Form G.H.117 is not received by that date. Below is the notation that should appear on a Work Sheet if a claim requires a "117" suspension of benefits that is to become effective as of November 22d (November 5th is the first day of disability):

."Pay 11/5 and 117 suspend 11/22."

It is the practice to give two weeks' notice of either type of suspension of benefits. Accordingly, a letter giving notification of a suspension of benefits that is to become effective as of December 20th must be mailed to the policyholder no later than December 7th. If the date as of which a suspension of benefits is to become effective falls within two weeks of the date a claim is approved for payment, then the "suspend" letter should be mailed to the policyholder on the date the claim is approved for payment. On the other hand, if the date as of which a suspension of benefits is to become effective is more than two weeks subsequent to the date a claim is approved for payment, it is necessary to put the claim on call-up for a date two weeks prior to the date the suspension is to become effective. If a claim showing no date of return to work shows an estimated date of return to work that elapsed before the claim was approved for payment, it is not possible to give two weeks' notice of a suspension of benefits; in cases of this type, the "suspend" letter should, of course, be mailed to the policyholder on the date the claim is approved for payment.

"TO AND EXPLAIN" PAYMENTS

If a physician's report indicates that an Employee is expected to return to work on a date which is in the future in relation to both the date of the physician's report and the date the claim is approved for payment, the payment of benefits is suspended. Different action must be taken, however, if a physician's report indicates that an Employee was able to return to work on a date which, in relation to the date of the physician's report, is in the past.

Specifically, benefits are payable only to an estimated date of return to work that precedes the date of the physician's report, even if the Employee actually returns to work on a later date. For example, if a physician's report dated May 16th indicates that an Employee was able to return to work on May 14th, benefits are payable only to (not to and including) May 14th. A payment of this kind is called a "to and explain" payment.

The second paragraph of Form G.864, a printed form letter prepared by the Claim Payment Typists, is used to notify a policyholder of a "to and explain" payment. This letter requests medical certification of additional disability if the Employee was totally disabled for any period after the date to which benefits were paid. Below is the notation that would appear on a Work Sheet to indicate to the Claim Payment Typists that the policyholder is to be notified of the "to and explain" payment discussed above:

"Pay 5-1 to 5-14 and explain."

If a medical report submitted in response to a "to and explain" letter certifies that an Employee was totally disabled until a later date, benefits may be paid to that date.

"THROUGH AND EXPLAIN" PAYMENTS

Benefits are payable through (to and including) an estimated date of return to work that precedes the date of a physician's report if the Employee receives treatment on the estimated date of return to work. Benefits are paid through the estimated date of return to work in a case of this kind because we do not know the time such treatment was rendered and because it may have been rendered too late in the day to permit the Employee to return to work.

A claim requiring a "through and explain" payment would be one on which the attending physician, in a report dated June 27th, indicates that the Employee was able to return to work on June 23d and also indicates that the Employee was treated on June 23d. In such a case, benefits would be paid only through June 23d even if the Employee actually returned to work on a later date.

The first paragraph of Form G.864 is used to notify a policyholder of a "through and explain" payment. Below is the notation that would appear on a Work Sheet to indicate that the "through and explain" payment discussed above is to be explained to the policyholder:

"Pay 6-12 through 6-23 and explain."

If a medical report submitted in response to a "through and explain" letter certifies that an Employee was totally disabled until a later date, benefits may be paid to that date.

"MORE MEDICAL" CLAIMS

Benefits can be paid to the date of an Employee's return to work only if this date falls within seven days of an estimated date of return to work previously furnished by an attending physician, or, in the case of a "no prognosis" claim, within seven days of a "117" suspension date - otherwise the claim is a "more medical" claim: one that requires medical certification that the Employee was actually disabled until the date he returned to work.

The first paragraph of Form G.868, a printed form letter prepared by the Claim Payment Typists, is used to notify a policyholder that the Employee must obtain medical certification of such additional disability. To initiate the preparation of a "more medical" letter, it is necessary to write the words "More Medical" on the Work Sheet attached to the claim.

The action to be taken following receipt of a report submitted in response to a "more medical" letter depends upon the information given in the report. If the report indicates that the Employee was totally disabled until the date he returned to work, benefits should be paid to that date; if the report indicates that the Employee was first able to resume work on a date prior to the date he did so, however, then a "to and explain" or a "through and explain" payment, whichever is applicable, should be made; if the report shows the same estimated date of return to work previously furnished, it is necessary to inform the policyholder by letter that no additional benefits are payable. (NOTE: A "to and explain" letter should not be used to explain this last situation, since this letter mentions the issuance of a check paying additional benefits.) If no report is received within one month of the date a "more medical" letter is mailed to a policyholder, the claim should be closed out.

BENEFIT PAYMENT PERIOD

The term "benefit payment period" refers to the maximum number of weeks of benefits an Accident and Sickness policy provides for one continuous period of disability or for successive periods of disability due to the same or related cause or causes. Thus, a policy which provides 13 weeks' benefits is said to have a benefit payment period of 13 weeks, and one which provides 26 weeks' benefits is said to have a benefit payment period of 26 weeks.

A few policies have a benefit payment period of 20 weeks, 39 weeks, or 52 weeks.

A benefit payment period begins on the benefit due date and ends on the date as of which benefits expire.

PLANS OF INSURANCE

Numerical symbols are used on Work Sheets to indicate the duration of the waiting period and the benefit payment period of an Accident and Sickness policy. The duration of the waiting period, it is important to note, is usually expressed in terms of the date as of which benefits become due and payable: the benefit due date. Accordingly, a policy that imposes a seven-day waiting period for all disabilities and provides benefits for a maximum of 13 weeks would be described on a Work Sheet as having a "8-13" plan of Accident and Sickness insurance.

In addition to the 8-13 plan, there are three other standard plans of Accident and Sickness insurance, each differentiated by the duration of the waiting period and the duration of the benefit payment period: the 4-13 plan, the 4-26 plan, and the 8-26 plan.

The 4-13 plan imposes a three-day waiting period for all disabilities and provides benefits for 13 weeks.

The 4-26 plan imposes a three-day waiting period for all disabilities and provides benefits for 26 weeks.

The 8-26 plan imposes a seven-day waiting period for all disabilities and provides benefits for 26 weeks.

Each of the four standard plans of Accident and Sickness insurance may be modified by the "first day injury" provision. On Work Sheets the number 1 is used as a prefix to the numbers mentioned above to indicate that a policy contains the "first day injury" provision. Accordingly, the symbol "1-8-13" indicates that a policy provides benefits from the first day of a period of disability due to an injury, from the eighth day of a period of disability due to sickness, and, in either case, for a maximum of 13 weeks. There are also 1-4-13, 1-4-26, and 1-8-26 plans of Accident and Sickness insurance, the number 1 in each of these symbols indicating that benefits are payable from the first day of a period of disability due to an injury. The phrase "NOA first day" is sometimes used to indicate that a policy contains the "first day injury" provision; in this phrase, the letters NOA stand for "nonoccupational accident."

Each of the four standard plans of Accident and Sickness insurance may also be modified by two provisions which affect the duration of a waiting period. These two provisions are the "first day hospital" provision and the "retroactive" provision. On Work Sheets, each of these provisions is indicated by words or phrases instead of numerical symbols. The words "first day hospital" appearing in the description of an Accident and Sickness policy indicate that it contains the "first day hospital" provision. The words "retroactive after 30 days" appearing in the description of an Accident and Sickness policy indicate that it contains a provision which waives the waiting period if an Employee is totally disabled for more than 30 days.

"FIVE-DAY" POLICIES

Aside from New York DBL "statutory" policies, some Accident and Sickness policies provide benefits only for days of disability that fall on an Employee's scheduled working days. Because the Employees of most of our policyholders work only five days a week - usually Monday through Friday - most policies of this type provide benefits on the basis of a five-day work week and are therefore called "five-day" policies.

The fact that five-day policies exclude the payment of benefits for days of disability which are also days on which an Employee is not scheduled to work - for example, a Saturday and a Sunday - accounts for three important administrative procedures to be observed in paying claims filed under these policies:

1. A Saturday or a Sunday is not to be used as a benefit due date - only a day of disability that is also a scheduled working day can be used as a benefit due date. (A day of disability on which an Employee is not scheduled to work - again, a Saturday or a Sunday - may, however, be used as a day of the waiting period.)

2. The payment of benefits is suspended as of the Friday preceding an estimated date of return to work.

3. When an Employee returns to work on a Monday, benefits are paid only to and including the preceding Friday.

The most important point to remember about five-day policies is that they provide payment of one-fifth of an Employee's Weekly Benefit for each compensable day of total disability. For example, an Employee insured under a policy of this type for a Weekly Benefit of $35 would be paid $7 for one day of total disability, $14 for two days of total disability, and so on.

Although a five-day policy may be described on a Work Sheet as providing 13 "weeks" of benefits, such a policy provides benefits for only 65 days of total disability. Similarly, one that provides 26 "weeks" of benefits provides only 130 days of benefits for one continuous period of disability or for successive periods of disability due to the same or related cause or causes. It is for this reason and also because five-day policies provide one-fifth of an Employee's Weekly Benefit for each compensable day of total disability that the words FIVE DAY WEEK must be written in red ink on any pay card prepared for a claim submitted under a five-day policy.

If an Accident and Sickness policy provides benefits on the basis of a work week of five days or less, the Work Sheet describing it will be noted accordingly. In the absence of such a notation, it is to be assumed that a policy provides one-seventh of an Employee's Weekly Benefit for each compensable day of total disability, regardless of the Employee's scheduled work week.

BENEFIT RATES

Although Accident and Sickness benefits are not necessarily intended to replace salary, the amount of an Employee's Weekly Benefit is usually determined by the amount of his basic weekly salary.

This underwriting principle is reflected first of all in a schedule of Weekly Benefits that is based on salary classification, as illustrated in the following table:

Basic Weekly Salary	Weekly Benefit
Less Than $35.00	$21.00
$35.00 but less than 40.00	25.00
40.00 but less than 50.00	28.00
50.00 but less than 60.00	35.00
60.00 and over	42.00

Under some policies, one-half of an Employee's basic weekly salary is the amount of his Weekly Benefit. The Schedule of Insurance of a policy incorporating this benefit formula would stipulate that the Weekly Benefit of each Employee is "One-half the Employee's basic weekly salary, with a minimum weekly benefit of $30 and a maximum of $60." The Weekly Benefit of an Employee insured under such a policy would be $30 if his basic weekly salary is $60 or less, $46.25 if it is $92.50, $60 if it is $120 or more, and so on.

A variation of this formula increases the amount of the Weekly Benefit to 60 percent of an Employee's basic weekly salary, establishes a maximum Weekly Benefit but no minimum Weekly Benefit, and requires a "rounding out" of the amount of any Weekly Benefit that is not a multiple of $1. The Schedule of Insurance of a policy incorporating this benefit formula would stipulate that "The amount of the Weekly Benefit shall be an amount equal to 60 percent of an Employee's basic weekly salary, as determined by the Employer, to a maximum Weekly Benefit of $65" and that "Any Weekly Benefit not a whole number of dollars shall be raised to the nearest whole dollar." The Weekly Benefit of an Employee insured under such a policy would be $60 if his basic weekly salary is $100, $56 (a rounding out of $55.50) if it is $92.50, $65 if it is $108.35 or more, and so on.

Most policyholders whose Employees are insured for a Weekly Benefit of the "percentage" type (one that constitutes one-half, 60 percent, or two-thirds of an Employee's basic weekly salary) report the amount of the Weekly Benefit an Employee is eligible to receive. Some of these policyholders, however, erroneously report as a benefit what is actually the

Employee's basic weekly salary; concerning claims in this category, it should be remembered that the amount of a Weekly Benefit payable under any policy rarely exceeds $100, and that a Weekly Benefit in excess of $50 is usually a whole-dollar amount, not a quarter-dollar or half-dollar amount such as $36.25 or $42.50.

A third benefit formula, which applies to only a few policies, does not take salary into consideration, but instead provides one benefit rate (e.g. $35) for all Employees. A variation of this third formula provides one benefit rate (e.g., $36) for all female Employees, and a different benefit rate (e.g., $42) for all male Employees.

As stipulated in the insuring clause of Accident and Sickness policies, the amount of the Weekly Benefit payable to an Employee during any one continuous period of total disability is "the amount of Weekly Benefits ... in force on account of the Employee" on the date he becomes totally disabled. This important point is also reflected in the "actively at work" provision, which is found in the Schedule of Insurance and is usually worded as follows:

> "The amounts of insurance on the effective date hereof are determined by the Employee's earnings or class on that date. Any increase or decrease in such amounts of insurance in accordance with the Schedule of Insurance ... shall be effective on the date of change in the Employee's earnings or class provided the Employee is actively at work on that date, or, if not then actively at work, on the date of his return to active work."

Because the amount of an Employee's Weekly Benefit can be increased or decreased as a result of a change in his salary classification or employment status, a claim should be paid at the benefit rate furnished by the policyholder, even if it is lower or higher in amount than the Weekly Benefit reported on the Employee's previous claim - provided, of course, that the benefit rate furnished in instances of this kind appears in the benefit schedule appearing on the policyholder's Work Sheet.

OCCUPATIONAL DISABILITIES

Most Accident and Sickness policies exclude payment for both occupational injuries and occupational diseases. Some Accident and Sickness policies, however, provide benefits for occupational injuries, others provide benefits for occupational diseases, and still others provide benefits for both occupational injuries and occupational diseases. In addition, some policies provide Supplementary Occupational Benefits for disability due to either an occupational injury or an occupational disease - policies of this type stipulate that "In the event ... the Employee is entitled to any benefits for time lost from work under any Workmen's Compensation Law or Act or Occupational Disease Law or Act, the amount of any Weekly Benefits payable under the Group Policy ... shall be reduced by the amount of such benefits."

If one of the special provisions mentioned above is found in an Accident and Sickness policy, the Work Sheet describing it will be noted accordingly. In the absence of such a notation, it is to be assumed that an Accident and Sickness policy excludes payment for both occupational injuries and occupational diseases. A policy of this type provides benefits for"(A) any injury not arising out of, or in the course of, any employment for wage or profit, or (B) any sickness not entitling (the Employee) to benefits under any Workmen's Compensation Law."

It is important to note that the first part of this usual "occupational disabilities" exclusion precludes payment not only for any injury an Employee sustains as a result of his employment with the policyholder, but also for any injury sustained in part-time or casual employment - in "any employment for wage or profit." Although an injury that an Employee sustains in part-time or casual employment is usually sustained during the hours or on the days that he does not work for the policyholder, an injury that an Employee sustains as the result of his employment with the policyholder is usually sustained during his regular working hours (e.g., 9:00 a.m. to 5:00 p.m.). An injury sustained during working hours is not the only criterion of an occupational injury, however - a more specific one is whether, at the time the injury was sustained, the Employee was performing work for the policyholder. Thus, an injury sustained by an Employee as the result of "horseplay" or an altercation with a fellow Employee might not be considered an occupational injury, but an injury sustained by an Employee while on a business trip for the policyholder usually is.

It is also important to note that, because it permits the payment of benefits for "any sickness not entitling (the Employee) to benefits under any Workmen's Compensation or Occupational Disease Law," the second part of the "occupational disabilities" exclusion permits benefits to be paid for a disease that is occupational but, for some valid reason, is not compensable as such.

Although an occupational injury can be any type of injury that is sustained in the course of employment for wage or profit, only a few diseases are identifiable as occupational diseases, which "are the outcome of long exposures to noxious influences during work and occur either exclusively or with particular frequency among the workers in a specific industry." In other words, certain working environments result in exposure to metals, chemicals, and other materials which, in the form of solids, dusts, liquids, gases, or vapors, constitute known health hazards.

One disease which is intrinsically occupational in origin is a pneumoconiosis, the term for a number of lung disorders which result from the continued inhalation of dust particles. The dust which causes a pneumoconiosis can be that of anthracite coal, asbestos, beryllium, cotton, iron, or silica. Thus, anthracosis, asbestosis, berylliosis, byssinosis, siderosis, and silicosis are classified as industrial pneumoconioses.

Two diseases which are invariably occupational in origin are metal poisoning (a toxic state resulting from the continued inhalation or absorption of such metals as lead, mercury, and arsenic) and chemical poisoning (a toxic state resulting from the continued inhalation or absorption of such chemical compounds as ammonia, carbon tetrachloride, benzol, acids, alkalis, and industrial solvents).

One condition which can be occupational in origin is a contact dermatitis, especially one of the hands or arms. A dermatitis caused by a chemical, a metal, or a lubricating oil is usually occupational in origin, but this is not true of a dermatitis that results from an allergy to certain plants, trees, drugs, cosmetics, and so on.

Our Accident and Sickness claim forms contain three questions that reflect the "occupational disabilities" exclusion. The first asks the Employee to furnish details of the origin of his disability if it is due to an accident. The second asks the attending physician to indicate whether or not the Employee's sickness or injury arose out of his employment. The third asks the policyholder to indicate whether or not the Employee's disability has been considered in connection with a Workmen's Compensation coverage. The various combinations of answers to these three questions form the basis for the procedures that are followed in processing a claim based on a disability that can be or is occupational in origin. These procedures are as follows:

1. If only the Employee or the attending physician indicates that the disability is occupational in origin - and the policyholder indicates that no claim for Workmen's Compensation benefits has been filed or else omits an answer to the question concerning this possibility - the claim may be approved for payment. In cases of this type, however, the payment of the claim should be qualified by a letter to the policyholder which explains the statement made by the Employee or the attending physician and explains also that the claim has been approved for payment "on the assumption that no claim for Workmen's Compensation benefits based on the same cause or period of disability has been filed, and that our interests will be protected in the event such a claim is filed."

2. If both the Employee and the attending physician indicate that the disability is occupational in origin, but the policyholder does not answer the question concerning a claim under a Workmen's Compensation coverage, the claim should not be approved for payment; instead, the policyholder should be sent a letter explaining the statements made by both the Employee and the attending physician and asking if the disability has been considered in connection with a Workmen's Compensation coverage.

3. If both the Employee and the attending physician indicate that the disability is occupational in origin, but the policyholder states that the disability has not been considered in connection with a Workmen's Compensation coverage, the claim should not be approved for payment; instead, the policyholder should be sent a letter explaining the statements made by both the Employee and the attending physician and asking why the disability has not been considered in connection with a Workmen's Compensation coverage.

4. If the policyholder states that the disability has been considered in connection with a Workmen's Compensation coverage, the claim should be declined for payment, regardless of any statement made by the Employee or the attending physician concerning the origin of the disability.

Before they are considered for payment, all claims based on a disability which appears to be occupational in origin, including any disability which results from part-time or casual employment, are to be referred to a Senior Claims Approver for review and instructions as to their disposition. All claims based on a disability that is occupational in origin and is excluded from payment should be declined and referred to a Senior Claims Approver as declined claims.

DEATH CASES

If an Accident and Sickness claim shows that an Employee has died, benefits are payable through (to and including) the date of death.

In Accident and Sickness death cases, benefits are properly payable to the executor of the will or the administrator of the estate of the deceased Employee. Benefits in death cases may, therefore, be paid to any person who, in a legal document accompanying the claim form, is named as executor of the will or administrator of the estate of the Employee.

Some death cases involve a delay in probating the Employee's will or in having someone appointed administrator of the estate of an Employee who died without leaving a will; consequently, a claim showing that the Employee has died is not always accompanied by a legal document naming an executor or an administrator. In such cases, and at the suggestion of the policyholder, benefits are payable to the person identified by the policyholder as the spouse or the beneficiary of the Employee. To safeguard the Company's legal position in such instances, it is necessary to explain to the policyholder by check letter that benefits have been paid to the spouse or the beneficiary on the basis of the suggestion to that effect.

In some death cases, no letters testamentary or letters of administration are submitted, and no payee is designated by the policyholder. If the policyholder in cases of this kind maintains a Metropolitan Group Life

insurance policy, the Group Death Claim file should be requisitioned, and Accident and Sickness benefits should be paid to the beneficiary of the Group Life insurance policy. The action taken in cases of this kind should be explained to the policyholder by check letter.

In other Accident and Sickness death cases, no letters testamentary or letters of administration are submitted, no payee is designated by the policyholder, and no Metropolitan Group Life insurance policy is maintained by the policyholder. In cases of this kind, it is necessary to send to the policyholder an "estate letter." An "estate letter" explains that, at the death of an Employee, Accident and Sickness benefits are properly payable to the executor of his will or to the administrator of his estate. It accordingly requests that the executor claim the benefits by submitting a copy of the letters testamentary or that the administrator claim the benefits by submitting a copy of the letters of administration. An "estate letter" then suggests that, if there is no executor or administrator, the benefits be claimed by the Employee's spouse or whoever assumed the expenses incident to the Employee's illness and burial. An "estate letter" also requests notification of the full name, age, and relationship to the Employee of any person who claims the benefits as one who assumed the Employee's final expenses.

An Accident and Sickness benefit check made payable to an executor or an administrator must specify the legal capacity of such a person, to prevent any possible misuse of the check and to safeguard the Company's legal position. Accordingly, the name and title of the executor or administrator, exactly as they are given in the letters testamentary or the letters of administration, should be typed on the pay card prepared for the claim. On the other hand, if benefits are paid to someone who is not an executor or an administrator, but is instead the spouse or the beneficiary of the Employee, no title or degree of relationship should appear on the pay card. For example, if benefits are payable to a Mrs. Mary T. Jones as wife or beneficiary of a deceased Employee, she should be identified on a pay card simply as "Mary T. Jones."

MENTAL DISABILITIES

Some Accident and Sickness policies exclude payment for disability due to an injury that is intentionally self-inflicted by an Employee while he is sane or insane. Aside from the relatively few policies that contain this exclusion, our Accident and Sickness policies in no way exclude or limit payment for total disability due to a mental disorder. The only question presented by a claim based on disability due to a mental disorder is whether the Employee is mentally competent to handle his financial affairs - specifically, whether he is mentally capable of endorsing benefit checks drawn to his order.

The question of mental competency does not arise when disability is due to a psychoneurotic disorder (e.g., anxiety reaction, conversion reaction, or obsessive-compulsive reaction) or to a personality disorder (e.g., adjustment reaction, situational reaction, or passive-aggressive behavior), but only when disability is due to a psychosis - for example, schizophrenia, paranoia, or a manic-depressive psychosis.

The mental competency of an Employee who is being treated for a psychosis should not be questioned, even if he has been hospitalized, so long as he signs the claim form; in such cases, the fact that the Employee is able (and was permitted) to sign the claim form is regarded as satisfactory evidence of his mental competency.

If a claim form submitted on behalf of an Employee who is being treated for a psychosis is not signed at all - meaning that the space reserved for the Employee's signature has been left blank - it is necessary to return the claim form to the policyholder and request that it be signed by the Employee. In cases of this kind, a photostatic copy of both sides of the claim form should be made before it is returned to the policyholder.

If a claim form is accompanied by documents (in either original or photostatic form) which show that someone has been legally appointed the guardian or the conservator of the estate of a mentally incompetent Employee, benefits should be paid to the guardian or conservator. In such cases, it is necessary to draw checks to the guardian or conservator in his legal capacity, exactly as shown in the appointment papers, to prevent any possible misuse of the benefit checks and to safeguard the Company's legal position. The name and title of the guardian or conservator, as shown in the appointment papers, should be typed on the pay card prepared for the claim.

If a claim based on disability due to a psychosis is signed by someone who is not identifiable as a legally appointed guardian or conservator, it is necessary, before considering the claim for payment, to determine whether an appointment has been made and, if so, to request a photostatic copy of the appointment papers; in cases of this kind, in other words, benefits should not be paid to someone other than the Employee (including the Employee's spouse or beneficiary) unless such a person is identified, in documents accompanying the claim form, as a legally appointed guardian or conservator.

Some policies contain a provision which permits benefits due a mentally incompetent Employee to be paid to the beneficiary of the Employee's Group Life Insurance policy. This provision, which is called the "facility of payment" provision, is usually worded as follows:

> "If any Weekly Benefits are payable under the Group Policy on account of disability due to, or accompanied by, mental disablement, such benefits may, at the option of the Insurance Company, be paid to the Beneficiary of record of the Employee so disabled."

The "facility of payment" provision is applied only when a claim form that shows disability due to a psychosis is signed by someone who is not identifiable as a legally appointed guardian or conservator. In such cases, it is necessary to inquire whether a guardian or conservator has been appointed, and, if so, to request a copy of the appointment papers; it is also necessary to suggest that the beneficiary claim benefits in accordance with the "facility of payment" provision by signing a statement to that effect if no guardian or conservator has been or is to be appointed. The letter to the policyholder should also request notification of the beneficiary's full name, age, and relationship to the Employee if benefits are to be paid in accordance with the "facility of payment" provision; it should also inquire whether there is any known reason why benefits should not be paid to the beneficiary.

The "facility of payment" provision and the "self-inflicted injury" exclusion usually are not mentioned in the description of an Accident and Sickness policy on a Work Sheet. Accordingly, it is good practice to determine, in applicable cases, whether an Accident and Sickness policy contains either of these stipulations.

All claims subject to either the "self-inflicted injury" exclusion or the "facility of payment" provision, as well as any claim presenting a question of the proper payee of Accident and Sickness benefits due an Employee who is being treated for a psychosis, should be referred to a Senior Claims Approver for review.

"FIRST DAY HOSPITAL" PROVISION

Some Accident and Sickness policies contain the "first day hospital" provision, which serves to shorten or in some cases to eliminate a waiting period.

The underscored portion of the following paragraph shows the wording of the "first day hospital" provision as it appears in a policy that also contains the "first day injury" provision and imposes a waiting period of seven days for disability due to sickness:

> "There shall be no waiting period in the case of disability due to injury, and, in the case of disability due to sickness, the waiting period shall be the first seven days of disability, <u>except that if the Employee becomes confined as a registered bed patient in a legally constituted hospital, the waiting period shall not extend beyond the day immediately preceding the day the Employee becomes so confined</u>."

A special version of Form G.H. 24-C is used to administer the "first day hospital" provision. This claim form requests the Employee to furnish three items of information if he was hospitalized as a bed patient during a period of total disability: the name and address of the hospital, the

date and time of his admission to the hospital, and the date and time of his discharge from the hospital. Benefits can be paid in accordance with the "first day hospital" provision only if the information furnished by an Employee on this claim form indicates that he was confined in a legally constituted hospital as a registered bed patient.

As used in the "first day hospital" provision, the term "legally constituted hospital" means the same as it does in our Hospital Expense policies. For purposes of the "first day hospital" provision, therefore, it is necessary to refer to the Hospital Directory published by the American Hospital Association or to the Hospital Standing Report files to determine the acceptability of any facility whose name does not include the word hospital or else indicates that the facility offers only a limited or specialized type of treatment, is incorporated for profit, or is operated by one or more doctors. If the AHA Hospital Directory or the Hospital Standing Report files show that such a facility is acceptable for purposes of Hospital Expense insurance, then it is also acceptable for purposes of the "first day hospital" provision. If a Hospital Standing Report shows that a given facility is not acceptable for purposes of Hospital Expense insurance, however, then an Accident and Sickness claim showing confinement in that facility cannot be considered for payment in accordance with the "first day hospital" provision, and the resultant payment of the claim should be explained to the policyholder by check letter.

If neither the AHA Hospital Directory nor the Hospital Standing Report files contain any information concerning a questionable facility identified by an Employee as a hospital, it is necessary to request a Hospital Standing Report to determine if the facility is acceptable as a legally constituted hospital. In cases of this kind, however, payment of the claim should not be delayed until the Hospital Standing Report is received; instead, benefits should be paid from the benefit due date that is otherwise applicable. Such a payment should be explained to the policyholder in a check letter that also explains that the facility is being investigated to determine if it is acceptable for claim purposes. If the Hospital Standing Report completed in cases of this kind shows that the facility is acceptable, the payment of the claim should be adjusted, and the adjusted payment should be explained to the policyholder by check letter. On the other hand, if the Hospital Standing Report shows that the facility is not acceptable for claim purposes, then this information should be transmitted to the policyholder in a letter that also explains that the payment of the claim cannot be adjusted.

The requirement of the "first day hospital" provision that an Employee be confined as a registered bed patient is fulfilled if an Employee is confined overnight or else for a period of 18 consecutive hours on any one date - provided, of course, that such confinement takes place in a legally constituted hospital. If an Employee indicates that he was not hospitalized overnight or for a period of 18 consecutive hours on any one date, his claim cannot be considered for payment in accordance with the "first day hospital" provision, and benefits should be paid from the benefit due date that is otherwise applicable. Such a payment should,

of course, be explained to the policyholder by check letter. In cases of this kind, however, it is good practice to review any available claim for Hospital Expense benefits based on the Employee's hospital treatment, to make certain that no Daily Benefits were paid for such treatment.

The most important point to remember about the "first day hospital" provision is that it becomes operative only if an Employee becomes confined as a registered bed patient in a legally constituted hospital on a date preceding the date that would otherwise be used as the benefit due date. This stipulation means, for example, that a claim otherwise subject to a seven-day waiting period can be paid in accordance with the "first day hospital" provision only if an Employee becomes hospitalized as a registered bed patient on or before the seventh day of disability; it also means, in terms of a seven-day waiting period, that benefits become due and payable on the eighth day of disability if an Employee is hospitalized on or after the eighth day of disability.

As indicated by the wording quoted at the outset, a policy that contains the "first day hospital" provision may also contain the "first day injury" provision. Accordingly, a claim based on disability due to an injury can be subject to both the "first day hospital" provision and the "first day injury" provision. In cases showing that an Employee sustained an injury and was hospitalized as a registered bed patient on the same date, however, the application of the "first day hospital" provision cancels the application of the "first day injury" provision. This means that, in such cases, the date of an Employee's admission as a bed patient to a legally constituted hospital is to be accepted as the benefit due date, even if the injury was sustained after 12 o'clock noon.

The application of the "first day hospital" provision does not, however, cancel the application of the "three hour rule." This important point means that any day on which an Employee works three hours or more cannot be considered a benefit due date in accordance with the "first day hospital" provision. Accordingly, if a claim shows that an Employee became hospitalized as a bed patient on January 10th after working four hours on that date, January 10th could not be considered the benefit due date; in such a case, the date of the second day of the Employee's hospital confinement - January 11th - would be the benefit due date.

Although it is necessary to explain to the policyholder the disposition of any case in which benefits are claimed but cannot be paid in accordance with the "first day hospital" provision, it is not necessary to explain the additional allowance of benefits that results when a claim is paid in accordance with this provision.

INJURY CLAIMS

As used in Accident and Sickness policies, the term "injury" means an injury sustained solely through accidental means. This important point is reflected in the wording of our Accident and Sickness claim forms, which request an Employee to furnish details of the origin of his disability if it is due to an accident. An accident is "an occurrence that is sudden, violent, and unexpected."

Because they do not result from an accident, such conditions as contact dermatitis (including the dermatitis of poison ivy, oak, or sumac), diabetic coma, epiliptic fits, heart attacks, and insulin reaction are not to be considered injuries. Because they do result from an accident, such conditions as abrasions, bites, burns, contusions, dislocations, scalds, and sprains are to be considered injuries.

As a result of an administrative ruling, sunburn also may be considered an injury, but only if the Employee attributes it to an accident and only if the description of the accident indicates that the sunburn was sustained unintentionally.

Also to be considered as an injury is an acute poisoning: the effects of the ingestion or inhalation of a toxic substance at a given time. Salmonella food poisoning, botulism, and the inhalation of a toxic gas or vapor are examples of acute poisoning. Not to be considered as an injury, however, is a chronic poisoning, which refers to the effects of the continued ingestion, inhalation, or absorption of a drug such as a barbituric acid compound, a metal such as lead or mercury, or a chemical such as an acid or a solvent. Chronic metal or chemical poisoning is, moreover, invariably occupational in origin.

A number of conditions can result either from an injury or from a disease process. Examples of such conditions are arthritis, bursitis, myositis, phlebitis, and tenosynovitis. Any such condition is to be considered an injury only if the Employee states that it results from an accident and only if the attending physician's report also indicates that it results from an accident.

Still another category of injuries is intentionally self-inflicted injuries. Some Accident and Sickness policies exclude payment for intentionally self-inflicted injuries by stipulating that "The insurance under the Group Policy does not cover intentionally self-inflicted injury, while sane or insane." Intentionally self-inflicted injuries result from suicide attempts, and are usually indicated by a diagnosis such as carbon monoxide poisoning, lacerations of both wrists (slashed wrists), acute poisoning due to an overdose of barbiturates, and so on. A claim based on any such injury should be recommended for declination in accordance with the exclusion quoted above only if information furnished by the attending physician or a mercantile agency indicates that the Employee is suffering from a mental or nervous disorder, or only if a claim previously submitted by the Employee indicates a history of a mental or nervous disorder. Because the "self-

inflicted injury" exclusion may not be noted on a Work Sheet, it is good practice, whenever a claim shows an injury that could have been self-inflicted, to determine whether the policy involved excludes payment for self-inflicted injuries.

It is important to remember that the payment of a claim based on an injury is subject to the administrative ruling which establishes the first day of disability on the basis of whether an injury is sustained before or after 12 o'clock noon. It must also be remembered, however, that the application of either the "first day hospital" provision or the "three hour rule" cancels the application of this ruling. The "first day hospital" provision cancels the application of the ruling if an Employee, as the result of an injury, is admitted to a legally constituted hospital as a registered bed patient on the same date the injury is sustained. The "three hour rule" cancels the application of the ruling if an Employee works more than three hours on the date he sustains an injury, even if the injury is sustained before 12 o'clock noon, as in the case of an Employee who is injured in a household accident at 10:00 a.m on May 5th after working from midnight to 8:00 a.m. on May 5th.

The administrative ruling discussed above establishes merely the first day of disability for a claim based on an injury, not the benefit due date. For example, if an Employee who is insured under a policy imposing a three day waiting period for all disabilities is injured at 6:00 a.m. on June 10th, June 10th would be the first day of disability, but benefits would not become due and payable until June 13th, the fourth day of disability. On the other hand, if the policy contained the "first day injury" provision, then, in the circumstances cited, June 10th would be not only the first day of disability, but also the benefit due date.

The "first day injury" provision and the administrative ruling discussed above are reflected in the wording of a question which appears in the Employee's section of all versions of Form G.H. 24-C. This question is the one which asks the Employee to describe and to give the date and the time of any accident causing disability. If an Employee does not furnish the date of an accident - and also does not indicate the date he first became disabled - the date to be accepted as the first day of disability is the first day of disability furnished by the attending physician. If an Employee furnishes the date but not the time of an accident, the date to be accepted as the first day of disability is the day following the date of the accident. It is not necessary to explain to the policyholder the choice of the first day of disability in cases of this kind.

If an Employee furnishes no details of an accident causing such an obvious injury as a fracture or a dislocation, he should be requested to complete a statement giving complete details of the accident, as required on the claim form, before a claim based on such an injury is considered for payment. If in cases of this kind the policyholder does not answer that question concerning the Employee's disability having been considered in connection with a Workmen's Compensation coverage, the letter requesting a description of the accident from the Employee should also request the

policyholder to indicate whether the Employee's injury is, is not, or is possibly occupational in origin.

In some instances an Employee indicates that his disability is the result of an accident, but the diagnosis furnished by his attending physician indicates that disability is actually due to a condition which cannot be traumatic in origin. For example, an Employee may state that an attack of acute appendicitis was caused by an accident. In such instances, the Employee's allegation of an accident should be ignored, and the claim should be considered for payment as a sickness claim. This means that the first day of disability in such cases should be established in accordance with the administrative ruling that determines the first day of a period of disability due to a sickness.

Instead of involving disability due solely to one or more injuries, an Accident and Sickness claim may involve one continuous period of disability due in part to an injury and in part to one or more sicknesses entirely unrelated to the injury. If it shows that the injury was sustained on or before the first day of total disability, a claim of this type should be considered for payment as an injury claim, and in accordance with the "first day injury" provision, if applicable. On the other hand, if a claim involving disability due to both an injury and one or more unrelated sicknesses shows that the injury was sustained after total disability due to sickness began, the claim should be paid as a sickness claim - unless the policy involved contains the "first day injury" provision and the injury was sustained prior to the expiration of the waiting period applicable to disability caused by sickness.

There are four categories of injury claims which are to be referred to a Senior Claims Approver for review. They are:

1. Claims showing self-inflicted injuries.
2. Claims showing injuries resulting from a physical altercation.
3. Claims showing injuries sustained as the result of committing an unlawful act.
4. Claims based on disability which commences more than one week after the date the injury was sustained.

Also to be referred to a Senior Claims Approver for review is any claim presenting a question of whether it involves disability due to an injury or to a sickness.

RECURRENT CLAIMS

A claim for Accident and Sickness benefits should be considered for payment as a recurrent claim if it is based on a disability that is due to the same

or related cause or causes as the disability reported on the Accident and Sickness claim previously submitted by the Employee involved.

An Accident and Sickness policy may contain a provision stipulating that two periods of disability are to be considered unrelated as to cause if they are separated by at least two weeks of active work. This special provision, which is called the "two-week" recurrent claim provision, is usually worded as follows:

> "If the Employee is at active work with the Employer for a continuous period of two weeks or more between two periods of disability, the second period of disability shall not be considered as being due to the same or related cause or causes as the preceding period of disability."

If an Accident and Sickness policy contains the "two-week" recurrent claim provision, the Work Sheet describing the policy will be noted accordingly.

In the absence of such a notation, an Accident and Sickness claim that is causally related to a previous one should be considered for payment as a recurrent claim on the basis of the "three months" rule. This administrative ruling stipulates that two periods of disability are to be considered unrelated as to cause if they are separated by at least three months of active work. In the few policies which incorporate it as a provision, the "three months" rule is usually worded as follows:

> "If the Employee is at active work with the Employer for a period of three months between two periods of disability, the second period of disability shall not be considered as being due to the same or related cause or causes as the first disability."

It is important to note that the wording of both the "two-week" recurrent claim provision and the "three months" rule, as quoted above, merely stipulates that two periods of disability are to be considered causally unrelated if they are separated by a specified period of active work (i.e., at least two weeks or at least three months of active work). Although one of the purposes of this wording is to imply that the claim submitted for the second such period of disability is to be considered for payment as a "new" claim, this wording should not be construed as implying also that two periods of disability separated by less than two weeks or less than three months of active work are to be considered related as to cause; two periods of disability can be considered related as to cause only if each is due to the same or related cause or causes. In other words, both the "two-week" recurrent claim provision and the "three months" rule govern the payment of disabilities that are due to the same or related cause or causes, not the payment of disabilities that are entirely unrelated as to cause. (So long as two periods of disability are entirely unrelated as to cause, they need be separated by only one day of active work to be considered for payment as such.)

Two weeks, the period of time mentioned in the "two-week" recurrent claim provision, is always 14 days in duration. Three months, the period of time mentioned in the "three months" rule, is, however, variable in duration - a period of three months can last for 89 days, as does the period from February 1st to April 30th, or for a maximum of 92 days, as does the period from July 1st to September 30th. This does not mean, however, that a claim that is subject to the "three months" rule is to be considered a recurrence of a previous, causally-related claim because the Employee worked for a period of less than 93 days between the two periods of disability involved. Instead, a period of three months should always be determined "by the calendar." For purposes of the "three months" rule, therefore, a period of three months may consist of 89 days, 90 days, 91 days, or 92 days.

Neither the "two week" recurrent claim provision nor the "three months" rule applies to successive periods of disability due to a respiratory condition such as the common cold, a sore throat, pharyngitis, or influenza. This important payment procedure means, for example, that a cold contracted by an Employee in October is not to be considered a recurrence of a cold or any other type of respiratory condition contracted by him in September, since the predisposing factors in each instance can be different. In accordance with the stipulations of either the "two-week" recurrent claim provision or the "three months" rule, a claim based on a respiratory condition can be considered for payment as a recurrent claim only if the attending physician's report clearly indicates that such a claim involves a condition which is a sequel to the condition reported on a previous claim, as would be the case if an Employee was disabled by "post-influenzal debility" or a "post-influenzal syndrome" after being disabled by influenza.

In addition, neither the "two-week" recurrent claim provision nor the "three months" rule applies to periods of disability due to the same pregnancy - all such periods of disability are to be considered recurrent, since Accident and Sickness policies which provide benefits for disability due to pregnancy limit payment on the basis of "disability caused by <u>any one</u> pregnancy."

Besides being subject to either the "two-week" recurrent claim provision or the "three months" rule, recurrent claims are subject to that limitation which stipulates that "in no case shall such Weekly Benefits be payable for more than (13) weeks for ... successive periods of disability due to the same or related cause or causes." On the basis of this limitation, a recurrent claim may have to be limited in payment or declined for payment, depending upon the number of weeks and days of benefits issued in payment of the previous claim to which it is causally related. If submitted under a policy that provides a maximum of 13 weeks' benefits and paid as a recurrence of a previous claim for which 10 weeks' benefits had been paid, a claim showing five weeks of disability would, for example, qualify for a payment of only three weeks' benefits. No benefits could be issued in payment of a claim that is subject to the "two-week" recurrent claim provision or the "three months" rule and also involves a recurrence of a disability for which maximum benefits had been paid; such a claim would have

to be declined for payment on the basis that the Employee had already been paid the maximum (13) weeks' benefits his Accident and Sickness policy provides for successive periods of disability due to the same or related cause or causes.

When a claim is paid as a recurrent claim, no waiting period is charged; instead, benefits are paid from (beginning with) the first day of the recurrent disability. Because this payment procedure results in an additional allowance of benefits (either three days' benefits or seven days' benefits, depending on the duration of the waiting period involved), it must be explained to the policyholder, to avert the return of the benefit check on the assumption that it constitutes an overpayment. The first paragraph of Form G.863, a printed form letter prepared by the Claim Payment Typists, is used to notify a policyholder that a claim has been approved for payment as a recurrent claim and that benefits have therefore been paid from the first day of the recurrent disability.

To indicate to the Claim Payment Typists that this letter is to be sent to the policyholder, it is necessary to note the Work Sheet to show that a claim has been approved for payment as a "continuous" claim. (NOTE: In any correspondence with the policyholder, the word "continuous" should not be used to refer to a recurrent claim.) Below is an example of the notation that would appear on a Work Sheet to indicate to the Claim Payment Typists that a policyholder is to be notified by means of Form G.863 that a claim has been approved for payment as a recurrent claim and that October 3d is the first day of the recurrent disability:

"Pay 10/3 continuous claim and explain."

Form G.863 can be used to notify a policyholder that the payment of a recurrent claim also involves a "date of medical" payment or a suspension of benefits based on an estimated date of return to work furnished by the attending physician. The payment of a recurrent claim must be explained to a policyholder by a check letter, however, if such a claim also requires a "to and explain" payment, a "through and explain" payment, a "117" suspension of benefits, or a cancelation of the Employee's Accident and Sickness insurance as the result of payment of the maximum benefits he is entitled to receive for successive periods of disability due to the same or related cause or causes.

RETROACTIVE PROVISION

Some Accident and Sickness policies contain what is called the "retroactive" provision. This provision results in a waiver of the waiting period if an Employee is totally disabled for a certain number of days, whether disability is due to an injury or to a sickness.

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"Pay 10/3 continuous claim and explain."

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RETROACTIVE PROVISION

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The "retroactive" provision is usually worded as follows:

> "In no case shall such Weekly Benefits be payable for the first (seven) days of disability; except if such disability continues for more than (30) days the benefits will be payable for the first seven days."

The number of days of disability mentioned in a "retroactive" provision is variable; instead of being 30 days, as in the provision quoted above, it can be a minimum of 14 days or a maximum of 35 days.

It is also important to note that a claim can be paid in accordance with a "retroactive" provision only if a period of disability exceeds the number of days of disability mentioned in the provision. For example, benefits can be paid in accordance with the "retroactive" provision quoted above only if an Employee becomes disabled for a period of at least 31 days.

The additional allowance of benefits provided by a "retroactive" provision should be included in the check issued in initial payment of a claim that is paid after the expiration of the period of disability mentioned in the provision (e.g., 30 days). If a claim is paid before the expiration of this period - and provided that the attending physician's report indicates that the Employee will be totally disabled for the requisite number of days - the claim should be put on call-up for the date on which this period expires, and the additional allowance of benefits should be included in the first check issued thereafter.

The "standard" wording of a "retroactive" provision does not specify consecutive days of disability. Accordingly, the days of disability mentioned in a "retroactive" provision such as the one quoted above can be accumulated on an intermittent basis, either during one period of disability interrupted by one or more days of work, or during two or more successive, causally-related periods of disability. To illustrate how this important point applies to the payment of a recurrent claim, let us assume that an Employee whose policy contains a 30-day "retroactive" provision submits claims for two successive, causally-related periods of disability. Let us assume that the first claim shows that the Employee was disabled for only 20 days. Because this first claim involves less than 31 days of disability, it cannot be paid in accordance with the "retroactive" provision of the Employee's policy; instead, a waiting period must be charged. If this waiting period is one of seven days, the Employee would receive only 13 days' benefits for the first period of disability. Now let us assume that the second claim submitted by this Employee shows that he was disabled for 15 days. Because this second claim is causally related to the first, it is paid as a recurrent claim; consequently, no waiting period is charged. More important, however, is the fact that the total of 35 days of disability accumulated by the Employee as the result of two successive, causally-related periods of disability exceeds the 30 days of disability mentioned in the "retroactive" provision of his policy. This cumulative period of disability therefore permits a waiver of the waiting period that was charged against the first claim when it was approved for payment. Consequently, the check issued

in payment of the second claim should not only pay benefits from the first day of the recurrent disability, but should also include an additional allowance of seven days' benefits, representing payment for the seven-day waiting period that was charged when the first claim was approved for payment. Claim payments of this type should be explained by check letter, so that the policyholder does not return the check on the assumption that it constitutes an overpayment.

It is important to note that one version of the "retrcactive" provision requires that an Employee be disabled for a certain number of days that are consecutive and also are working days. A "retroactive" provision of this type stipulates that the waiting period may be waived only if an Employee "is continuously totally disabled for a period of (10) consecutive working days or more...."

PREGNANCY CLAIMS

An Accident and Sickness policy either excludes or limits the payment of benefits for disability due to pregnancy or a complication of pregnancy.

Pregnancy Exclusion

A policy which excludes payment for disability due to pregnancy or its complications stipulates that "No Weekly Benefits shall be paid for disability caused by pregnancy or resulting childbirth or complications."

Existing Pregnancy Exclusion

Instead of excluding payment for any period of disability due to pregnancy or its complications, an Accident and Sickness policy may merely exclude payment for disability due to a pregnancy which was in existence on the effective date of the policy or on the date the Employee's insurance was issued. This exclusion, called the "existing pregnancy" exclusion ("EPE"), is worded as follows:

> "No payment shall be made for disability caused by pregnancy or resulting childbirth or complications, if the pregnancy existed on the effective date of this certificate or on the effective date of the Employee's insurance."

Eight Months Rule

A liberalization of the existing pregnancy exclusion by the Board of Directors permits benefits to be paid for disability due to a pregnancy which terminates in delivery "more than eight months after such effective date." This liberalization, which is called the "eight months" rule, is not found in any Accident and Sickness policy. Because it is a Board of Directors' ruling, however, it applies to any Accident and Sickness policy that contains the existing pregnancy exclusion.

On the basis of the eight months rule, a claim subject to the existing pregnancy exclusion may be paid if the actual or estimated date of delivery is at least eight months subsequent to the date the Employee's insurance was issued. On the other hand, if the actual or estimated date of delivery is within eight months of the issue date, the claim must be declined for payment in accordance with the existing pregnancy exclusion.

If a claim subject to the existing pregnancy exclusion involves disability that commences within eight months of the issue date but the attending physician's report does not furnish the estimated date of delivery, or if such disability is due to an abortion, a miscarriage, or any prenatal complication of pregnancy, it is necessary - in the absence of information to the contrary - to obtain from the attending physician a statement indicating whether or not the Employee's pregnancy was in existence on the date her insurance was issued. Form 11767, a printed form letter prepared by the Claim Payment Typists, is used to request such a statement.

EPE With Waiver

A variation of the existing pregnancy exclusion permits the payment of benefits for disability caused by a pregnancy which exists on the issue date of the Employee's insurance if the insurance becomes effective within 31 days of the effective date of the policy. This exclusion, which is called "EPE with waiver" or the "EPE 31" exclusion, makes merely an indirect reference to the liberalized enrollment period of 31 days, as indicated by the underscored portion of the following wording:

> "No payment shall be made for disability caused by pregnancy or resulting childbirth or complications, if the pregnancy existed on the effective date of this certificate or on the effective date of the Employee's insurance, <u>except as may be specified in the Group Policy</u>."

The "eight months" rule also applies to the "EPE with waiver" exclusion.

Pregnancy Limitation

Most Accident and Sickness policies which provide benefits for disability due to pregnancy and its complications limit payment for such disability to a maximum of six weeks' benefits and also contain the existing pregnancy exclusion, as indicated by the wording of the following paragraph:

> "For disability caused by any one pregnancy or resulting childbirth or complications, not more than six weeks' benefits shall be paid; provided, however, that no payment of any kind shall be made for such disability if the pregnancy existed on the effective date of this certificate or on the effective date of the Employee's Accident and Sickness insurance."

Recurrent Pregnancy Claims

It is important to note that a policy which provides benefits for disability due to pregnancy or its complications limits payment on the basis of disability caused by "any one pregnancy." This wording requires that two or more periods of disability due to the same pregnancy be considered for payment as recurrent disabilities, even if they are separated by more than three months of active work, or, if the policy involved contains the "two-week" recurrent claim provision, by more than two weeks of active work. In more specific terms, this wording means that an Employee who is paid four weeks' benefits for disability due to a prenatal complication of pregnancy is eligible to receive only two weeks' benefits when, as a result of the same pregnancy, she terminates employment to await childbirth.

Post-Partum Disability

As the result of an administrative ruling, the limitation discussed above does not apply to a post-partum complication of pregnancy which causes disability after an Employee has worked for three months or more following a delivery (or, if the policy involved contains the "two-week" recurrent claim provision, for two weeks or more following a delivery). Any claim showing disability due to a post-partum complication of pregnancy should be referred to a Senior Claims Approver for review.

Pregnancy and Sickness

A claim showing disability due to pregnancy or its complications and to one or more conditions entirely unrelated to pregnancy requires individual consideration, since an exclusion or a limitation that applies only to pregnancy and its complications cannot be applied to a condition that is entirely unrelated to pregnancy. Accordingly, any "pregnancy and sickness" claim is to be referred to a Senior Claims Approver for instructions as to its disposition.

Payment of Claims

A claim involving a pregnancy which is expected to terminate in childbirth and to result in a period of at least six weeks of total disability is paid by one check for six weeks' benefits. In such cases, a waiting period is charged unless it has not expired as of the date the claim is approved for payment; in addition, the Employee's Accident and Sickness insurance is canceled as of her last day at work. Form G.569, a printed form letter prepared by the Claim Payment Typists, is used to notify the policyholder of such a cancelation of insurance. Accordingly, if a pregnancy claim permits a lump-sum payment of six weeks' benefits, it is necessary to indicate on the Work Sheet the date the Employee was last at work before becoming disabled. For example, if in such a case October 3d is the first day of disability and October 2d is the date on which the Employee last worked, the Work Sheet should be noted as follows:

"Pay 10/3 6 weeks' lump sum. Cancel 10/2/63."

The procedures discussed above apply only to a claim which permits a lump-sum payment of six weeks' benefits - that is, one involving a pregnancy which is expected to terminate in childbirth and to result in at least six weeks of total disability. Different procedures must be followed if a claim is based on disability due to an abortion, a miscarriage, or a prenatal complication of pregnancy, since in such cases disability may not last for six weeks.

Specifically, a claim based on disability due to an abortion, a miscarriage or a prenatal complication of pregnancy is paid on a weekly basis, like a claim based on an injury or a sickness, and the usual waiting period applicable to sickness is charged (it is modified, if applicable, by the "first day hospital" provision, a "date of medical" payment, and so on). If in cases of this type the attending physician's report furnishes an estimated date of return to work, the payment of benefits should be suspended. If no estimated date of return to work is furnished, it is best to allow only three weeks' benefits and initiate a "117" suspension of benefits. If disability in cases of this type lasts for more than six weeks, it is necessary to cancel the Employee's Accident and Sickness insurance as of the date the six weeks of benefits expire. The policyholder must be notified of such a cancelation by means of Form G.569.

The following is an example of the wording that would appear on a Work Sheet to indicate that a policyholder is to be notified by means of Form G.569 that the six-week benefit payment period of a pregnancy claim payable on a weekly basis expired on June 29, 1964, and that the Employee's Accident and Sickness insurance is to be canceled as of that date:

> "Pay balance of maximum six weeks. Explain maximum six weeks' benefits paid through 6/29/64."

Post-Cancelation Disability

An Accident and Sickness claim may show that total disability due to pregnancy or its complications began after the Employee's Accident and Sickness insurance was canceled by reason of termination of employment or by reason of cancelation of the policyholder's Accident and Sickness policy or its entire Group Insurance Plan. Any such claim is to be evaluated for payment as though the policy involved contained a provision stipulating "If disability due to pregnancy commences after the cessation of the Employee's Accident and Sickness insurance, payment shall be made only if the pregnancy commenced prior to such cessation" - the provision stipulating "The cessation of the Employee's Accident and Sickness insurance shall not affect any claim incurred before such cessation" refers to a claim showing disability that begins before cancelation.

Accordingly, in cases of this kind, benefits are payable if the attending physician's report shows an estimated date of delivery that is within nine months of the date the Employee's Accident and Sickness insurance was canceled. This payment procedure reflects the fact that the period of

gestation of a term pregnancy is nine months. On the other hand, if the report of the attending physician in a case of this kind does not furnish an estimated date of delivery, or if the claim involves disability due to an abortion, a miscarriage, or a prenatal complication of pregnancy, it is necessary to request that the Employee obtain from the physician a statement indicating whether or not the Employee's pregnancy was in existence on the date her Accident and Sickness insurance was canceled.

AGE 60 LIMITATION

Some Accident and Sickness policies contain an "Age 60" limitation, which limits the payment of benefits for disabilities incurred during a period of 12 consecutive months by an Employee who is 60 years of age or more.

There are three versions of the Age 60 limitation. The third version will be discussed later; the first two versions are discussed in the paragraphs that follow.

The first version of the Age 60 limitation is worded as follows:

> "If the Employee be over age sixty at the time of any sickness disablement, he shall not be entitled to receive more than (thirteen) weeks' indemnity for sickness disability suffered during any twelve consecutive months."

The second version of the Age 60 limitation is worded as follows:

> "The Employee shall not be entitled to receive more than (thirteen) weeks' benefits during any twelve consecutive months for disability caused by sickness and incurred on or after reaching his sixtieth birthday."

Although they differ slightly in wording, the first two versions of the Age 60 limitation are identical in purpose and effect. Expressed or implied in the wording of each are the following points:

1. Payment is limited only for periods of disability that are due to a sickness; payment is in no way limited for periods of disability that are due to an injury. It is because they limit payment only for periods of disability due to a sickness that each of the first two versions of the Age 60 limitation is described on Work Sheets as a "sickness only" Age 60 limitation.

2. Payment is limited only for a period of disability (due to a sickness) that begins on or after the date an Employee becomes 60 years of age; neither of the first two versions of the Age 60 limitation applies to a period of disability which begins before the date an Employee becomes 60 years of age, even if during such a period of disability he does become 60 years of age.

3. Payment is limited for periods of disability due to a sickness whether such periods of disability are related or entirely unrelated as to cause.

The period of 12 consecutive months mentioned in each of the first two versions of the Age 60 limitation does not begin on the first day of a period of total disability; instead, it begins on the date as of which benefits become due and payable: the benefit due date. For example, if an Age 60 claim subject to a seven-day waiting period shows that the Employee became disabled on February 1, 1964, the claim would establish a period of 12 consecutive months that would begin on February 8, 1964. Such a period of 12 consecutive months would end on February 7, 1965.

An Employee's Accident and Sickness insurance is canceled as of the date of expiration of the maximum benefits (e.g., 13 weeks of benefits) payable in accordance with an Age 60 limitation, just as the Accident and Sickness insurance of an Employee under 60 years of age is canceled when he is paid maximum benefits for one continuous period of disability or for successive periods of disability due to the same or related cause or causes.

The one important question that each of the first two versions of the Age 60 limitation raises with respect to a current claim showing disability due to a sickness is whether the Employee involved was paid benefits for a sickness that began or ended within a period of 12 consecutive months preceding the benefit due date applicable to the current claim. If the answer to this question is "No," then payment of such a claim is in no way affected by either limitation. On the other hand, if the answer to this question is "Yes," then such a claim may have to be limited in payment or declined for payment.

To illustrate how either of the first two versions of the Age 60 limitation can serve to limit the payment of a claim, let us assume that an Age 60 claim showing five weeks of disability due to a sickness is submitted under a policy providing a maximum of 13 weeks' benefits. Next let us assume that the Employee involved had been paid a total of 10 weeks' benefits for a previous sickness (also subject to the Age 60 limitation) that had caused disability in the same period of 12 consecutive months that this current claim involves. In consequence of this previous payment of 10 weeks' benefits, only three weeks of benefits could be issued in payment of the current claim, and the Employee's Accident and Sickness insurance would have to be canceled as of the date these three weeks of benefits expire.

No benefits could be issued in payment of an Age 60 claim showing disability due to a sickness that began and ended in the same period of 12 consecutive months during which the Employee had previously been disabled by one or more sicknesses (also subject to the Age 60 limitation) for which the maximum benefits provided by his policy had been paid; such a claim would have to be declined for payment on the basis that the Employee had already been paid the maximum benefits payable in accordance with the Age 60 limitation of his policy.

A claim that is subject to either of the first two versions of the Age 60 limitation may be based on one continuous period of disability which "overlaps" two successive periods of 12 consecutive months. Concerning a claim of this type, it is important to remember that each of the first two versions of the Age 60 limitation merely stipulates that an Employee can be paid only 13 (or 26) weeks of benefits for sickness disabilities incurred during any twelve consecutive months; neither limits payment for sickness disabilities which commence in the same period of 12 consecutive months. Accordingly, each of the first two versions of the Age 60 limitation permits payment for that part of one continuous period of disability which causes absence from work during the second of two successive periods of 12 consecutive months, even if, owing to payment for previous sickness disabilities, payment must be limited or declined for that part of such a period of disability which causes absence from work during the first of the two successive periods of 12 consecutive months.

To illustrate one application of this important point, let us assume that the first claim submitted by an Employee whose claims are subject to either of the first two versions of the Age 60 limitation shows that he became totally disabled as the result of a sickness on January 1, 1964. If this Employee's policy imposes a waiting period of seven days for disability due to sickness, the period of 12 consecutive months established by this claim would begin on January 8, 1964; it would end on January 7, 1965. Let us assume that the claim shows 10 weeks of disability, from January 1 to and including March 10, 1964. Because a seven-day waiting period must be charged, the Employee would receive nine weeks of benefits for this period of disability.

Now let us assume that the next claim submitted by this Employee shows that he became disabled on October 26, 1964, by a second sickness, which the attending physician estimates will cause absence from work until March 25, 1965. It is important to note that this claim involves one continuous period of disability which overlaps two successive periods of 12 consecutive months: the one lasting from January 8, 1964, to January 7, 1965, and the one which would begin on January 8, 1965, and end on January 7, 1966. Because this Employee received a total of nine weeks' benefits for a sickness that previously caused disability in the first of these two periods of 12 consecutive months, he is eligible to receive only four weeks' benefits for that part of the second sickness which also causes disability in this first period of 12 consecutive months. This allowance of four weeks' benefits would represent payment for the inclusive period from November 2, 1964, the benefit due date applicable to the second claim, to November 29, 1964, and the Employee's Accident and Sickness insurance would have to be canceled as of the latter date.

The letter of cancelation to be written when payment is limited for the initial part of one continuous period of disability which overlaps two successive periods of 12 consecutive months should explain that additional benefits are payable if the Employee continues to remain totally disabled until after the date the second period of 12 consecutive months begins.

The claim involved should then be closed; it should be reopened only if medical evidence of such disability is submitted.

If such evidence is submitted, additional benefits become payable as of the date the second period of 12 consecutive months begins. It is important to note that in such instances no waiting period is charged if, as mentioned in the example discussed above, a waiting period was previously charged; only one waiting period can be charged during any one continuous period of disability.

It is also important to note that the allowance of benefits paid for that part of one continuous period of disability which causes absence from work during a "new" period of 12 consecutive months, when combined with the allowance of benefits paid for that part of the same period of disability which caused absence from work during the previous period of 12 consecutive months, cannot exceed the maximum benefits the Employee's policy provides for one continuous period of disability. Accordingly, for that part of his sickness which causes disability on and after January 8, 1965, the date the second period of 12 consecutive months would begin, the Employee in the example discussed above would be eligible to receive only nine weeks' benefits. This allowance of nine weeks' benefits, when combined with the four weeks of benefits the Employee received for that part of the same sickness which caused disability during the inclusive period from November 2 to November 29, 1964, would represent payment of the maximum 13 weeks' benefits his policy provides for one continuous period of disability. Accordingly, the Employee's Accident and Sickness insurance would have to be canceled again, on March 11, 1965, the date of expiration of these nine weeks of benefits.

Owing to the payment of nine weeks of benefits for the inclusive period from January 8 to March 11, 1965, the Employee in the example discussed above would be eligible to receive, in accordance with the Age 60 limitation of his policy, only four weeks of benefits for that part of any subsequent sickness causing disability prior to January 8, 1966, the date of a third period of 12 consecutive months would begin; and so on.

If in accordance with either of the first two versions of the Age 60 limitation payment must be declined for the initial part of one continuous period of disability which overlaps two successive periods of 12 consecutive months, the letter of declination should explain that additional benefits are payable if the Employee remains continuously and totally disabled until after the date the second period of 12 consecutive months begins. The claim involved should then be filed as a declined claim; it should be reopened only if medical evidence of such disability is submitted. If such medical evidence is submitted, no waiting period is charged if that part of the disability which caused absence from work during the first period of 12 consecutive months (the part of the disability for which payment was declined) exceeds the duration of the waiting period.

The third version of the Age 60 limitation is distinguished by two key terms: the phrase "all disabilities" and the word "commencing." The third version of the Age 60 limitation is worded as follows:

> "For all disabilities commencing on or after the Employee's sixtieth birthday and within any twelve consecutive months, a total of not more than (thirteen) weeks' benefits shall be paid."

The third version of the Age 60 limitation contains two important stipulations:

1. Payment is limited for "all disabilities" - for injuries and for sicknesses that are related or entirely unrelated as to cause. It is for this reason that the third version of the Age 60 limitation is described on Work Sheets as the "all disabilities" Age 60 limitation.

2. Payment is limited for all disabilities which commence in the same period of 12 consecutive months.

Since the third version of the Age 60 limitation limits payment on the basis of all disabilities which commence within the same period of 12 consecutive months, it does not permit payment for that part of one continuous period of disability which causes absence from work in the second of two successive periods of 12 consecutive months if payment is limited or must be declined for that part of the same disability which causes absence from work in the first of two successive periods of 12 consecutive months.

In other respects, however, the third version of the Age 60 limitation is administered in the same way as the first two versions - a period of 12 consecutive months begins on the benefit due date, the Employee's Accident and Sickness insurance is canceled when he is paid maximum benefits, and so on.

A letter notifying a policyholder of the cancelation of an Employee's Accident and Sickness insurance in accordance with any Age 60 limitation should be dictated - even if the cancelation results from payment for one continuous period of disability - because the Accident and Sickness insurance of an Employee whose claims are subject to an Age 60 limitation is subject to special procedures of cancelation and reinstatement.

For the same reason, a letter explaining the declination of an Age 60 claim that is more specifically a recurrent claim (one causally related to a previous claim) should indicate that the claim is being declined for payment in accordance with an Age 60 limitation rather than with the limitation which governs payment for successive periods of disability due to the same or related cause or causes.

A carbon copy of any letter explaining the disposition of a claim that is limited in payment or declined for payment in accordance with an Age 60 limitation should be sent to the appropriate Record Section of the Group Administration Division if the accounting system of the policyholder involved is "non-simplified." So that the Accident and Sickness insurance of the Employee involved may be canceled on the correct date and reinstated on the correct date, it is essential that such a letter, even if it is sent to a policyholder whose accounting system is "simplified," specify - not only with respect to the claim which is being limited in payment or declined for payment, but also with respect to each previous claim involved - the inclusive dates of each period of disability, of each period of 12 consecutive months, of each waiting period, of each period of disability for which benefits were paid, and of each period of disability for which benefits were not paid.

MAXIMUM BENEFIT PAYMENTS

An Employee's Accident and Sickness insurance is canceled when maximum benefits are paid for one continuous period of disability due to one or more causes, for successive periods of disability due to the same or related causes, for one or more periods of disability subject to an Age 60 limitation, or for one or more periods of disability due to the same pregnancy.

A carbon copy of any letter giving notification of a maximum benefit payment should be sent to the appropriate Record Section of the Group Administration Division if the accounting system of the policyholder involved is "non-simplified." The purpose of this procedure is to effect cancelation of the Employee's Accident and Sickness insurance as of the date through which maximum benefits are paid in one of the situations mentioned above.

If canceled by a maximum benefit payment, an Employee's Accident and Sickness insurance may be reinstated when he returns to active work for the policyholder on a full-time basis. In such instances, the date of the Employee's return to work must be noted on the pay card prepared for the claim involved. The purpose of this procedure is to facilitate evaluation of a subsequent claim in terms of the "two-week" recurrent claim provision or the "three months" rule.

After the date of the Employee's return to work has been noted on the pay card, the Form G.H. 59-C or the letter furnishing this date should be sent to the appropriate Record Section of the Group Administration Division if the accounting system of the policyholder involved is "non-simplified." The purpose of this procedure is to effect reinstatement of the Employee's Accident and Sickness insurance as of the date of his return to work.

The date an Employee returns to work following a period of disability for which maximum benefits were paid establishes not only the date his insurance is reinstated, but also, on the basis of the "two-week" recurrent claim provision or the "three months" rule, his eligibility to receive benefits for a subsequent, causally-related disability. Accordingly, if the date of an Employee's return to work following a period of disability for which maximum benefits were paid is not recorded on the pay card prepared for the claim involved, if it is not given in the claim file involved, or if the claim file is not available, it is necessary to request this important date from the policyholder before considering the payment of a later claim. If applicable, the file of the claim for which maximum benefits were paid should be requisitioned from the Hall of Records.

The later claim should then be considered for payment as a "new" claim or else declined for payment as a recurrent claim on the basis of two factors: whether or not it involves disability due to the same or related cause or causes as that shown on the claim for which maximum benefits were paid, and whether or not the "two-week" recurrent claim provision or the "three months" rule, whichever is relevant, can be applied.

INVESTIGATION OF CLAIMS

A "good" claim is, generally speaking, one that shows hospital or surgical treatment, or both, one that shows that an Employee received treatment before he stopped working, or one that shows that an Employee received treatment after the date of his return to work.

Some claims, however, are questionable as to the existence, cause, or duration of total disability. Such questionable claims may be investigated by having a mercantile agency submit a report of the Employee's activities and medical treatment or by having one of the Company's Medical Examiners submit a report based on a physical examination of the Employee.

Listed below are the types of claims which warrant investigation by a mercantile agency or a Medical Examiner, or both.

1. Claims based on a condition that is vague or ill-defined or merely symptomatic of a sickness or an injury. Examples of such conditions are pain, cramps, muscular weakness, cough, dyspnea, circulatory disturbance, rapid or irregular pulse, albuminuria, and hematuria.

2. Claims based on a condition that is questionable as a cause of total disability. Examples of such conditions are obesity, hypoglycemia, acidosis, dental caries, deafness, neurocirculatory asthenia, dyspepsia, diabetes, nervousness, fatigue, and psychoneurosis (anxiety, neurasthenia, conversion hysteria, and so on).

3. Claims showing a protracted period of disability, actual or estimated, that appears inconsistent with the given cause of disability.

4. Claims based on a condition for which the attending physician, in supplementary reports, repeatedly revises the estimated duration of total disability.

5. Claims showing that an Employee receives treatment infrequently, such as only once or twice a month.

6. Claims which are delayed in their submission and which also involve an extensive period of disability, either actual or estimated.

7. Claims submitted by Employees whose claim history shows frequent absences from work, seasonal absences from work, or prolonged periods of disability.

8. Claims submitted by Employees who, during a period of total disability, move permanently to another city or State, or temporarily take up residence in another State or abroad "for reasons of health."

9. Claims submitted by Employees who allege that they became disabled while on vacation, on a leave of absence, or on strike against the policyholder.

10. Claims submitted by persons whose employment with the policyholder has been terminated temporarily or permanently for any reason, including layoff or retirement.

11. Claims which a policyholder suggests be investigated.

Most of the situations listed above are reflected on a claim form on the date it is received. In such cases, a mercantile agency inspection or a physical examination should be instituted before the claim is considered for payment, and the policyholder should be notified by means of a dictated letter that consideration of the claim will be delayed. Such a letter should not mention the words investigation, physical examination, or Medical Examiner; instead, it should simply state that "Our consideration of the claim for Accident and Sickness benefits recently submitted by (John Smith) will be deferred, pending the completion of certain inquiries."

If a claim to be investigated is a "one-payment" claim (one showing that the Employee returned to work before the claim was submitted), it should not be investigated by means of a physical examination, because an Employee who has returned to work is ostensibly enjoying good health. Moreover, our Accident and Sickness policies permit a physical examination of an Employee only "while Weekly Benefits are being claimed under the Group Policy."

A Medical Examiner also should not be requested to conduct a physical examination of an Employee who resides in a remote rural area, as indicated by an address that mentions a box number or an "R.F.D." route; in cases of this kind, a mercantile agency should be requested to complete a report of the Employee's activities.

At present we utilize the services of three mercantile agencies: A. G. Fitzgerald Sons, the Retail Credit Company, and the Hooper-Holmes Bureau. The Fitzgerald agency completes narrative reports. The Retail Credit Company and the Hooper-Holmes Bureau, however, complete reports on forms having a question-and-answer format; moreover, both of these agencies offer two different types of reports for the evaluation of Accident and Sickness claims.

The two types of reports made available by the Retail Credit Company are its Group A & H Claim Report and its Continuance of Disability Report. The Group A & H Claim Report stresses the origin and dates of total disability, and should, therefore, be used for the evaluation of "one-payment" claims. The Continuance of Disability Report gives details of an Employee's current activities and medical treatment, and should, therefore, be used for the evaluation of "open" claims.

The two types of reports made available by the Hooper-Holmes Bureau are its SA (Group A & H) Report and its LDC (Continuance of Disability) Report. The SA report stresses the origin and dates of total disability, and should, therefore, be used for the evaluation of "one-payment" claims. The LDC report furnishes information on an Employee's current activities and medical treatment and should, therefore, be used for the evaluation of "open" claims.

The order forms of both the Retail Credit Company and the Hooper-Holmes Bureau provide space for listing instructions concerning any special information to be elicited in the course of an investigation. Such instructions are entered on the order form by the Claim Payment Typists, and accordingly are to be noted on the Work Sheet attached to the claim when an investigation is ordered. If all special instructions that an investigation requires cannot be listed in the space provided on an order form, it is necessary to furnish them in a dictated letter addressed to the mercantile agency. It is important that any such letter specify the type of report being ordered - that is, either a Group A & H Claim Report or a Continuance of Disability Report - to avoid creating the impression that a "special" report is being ordered; special reports are ordered only in unusual situations requiring a comprehensive investigation, and requests for them must always be approved by a Senior Claims Approver.

It is necessary to notify a policyholder by letter whenever the payment of benefits is suspended, terminated, or declined on the basis of information furnished in a report completed by a mercantile agency or a Medical Examiner. A letter of this type should not mention the words investigation, physical examination, or Medical Examiner; instead, if the

disposition of a claim is based on information furnished by a mercantile agency, the letter should merely state that "Information received at this Office indicates that ..." and then detail the relevant findings of the mercantile agency; if the disposition of the claim is based on information furnished by a Medical Examiner, the letter should simply state that "Medical information received at this Office indicates that ..." and then detail the relevant findings of the Medical Examiner.

DECLINATION SITUATIONS

An asterisk identifies those declination situations which are based on limitations or exclusions found in only some Accident and Sickness policies:

1. Total disability began before the date the Employee's Accident and Sickness insurance was issued.

2. Total disability (except that due to pregnancy) began after the date the Employee's Accident and Sickness insurance was canceled.

3. Period of disability too short; did not exceed duration of the waiting period.

4. Employee did not become totally disabled.

5. Insufficient proof of total disability.

6. No treatment rendered during period of total disability.

7. Treatment rendered by someone other than a legally licensed physician.

8. Disability due to an injury that arose out of or in the course of employment for wage or profit.

9. Disability due to a sickness for which the Employee is entitled to receive benefits under a Workmen's Compensation or Occupational Disease Law.

* 10. Payment excluded for disability due to pregnancy or its complications.

* 11. Payment excluded for disability due to a pregnancy that existed on the effective date of the Employee's Accident and Sickness insurance.

12. Recurrent pregnancy claim: Maximum six weeks' benefits previously paid for one or more previous periods of disability due to the same pregnancy.

13. Recurrent claim: Maximum benefits previously paid for one or more previous periods of disability due to the same or related cause or causes.

* 14. Recurrent Age 60 claim: Maximum benefits provided by Age 60 limitation previously paid.

15. Duplicate claim: Benefits previously paid for all or part of the same period of disability.

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MEDICAL REVIEW PROCEDURES

LONG TERM DISABILITY

The claim examiner in reviewing the medical reports submitted in support of the claim takes into consideration the claimant's history, present condition, diagnosis, frequency of treatments, extent of disability, and the prognosis. If, in the judgement of the claim examiner, there is no question that the claimant is disabled as defined by the Group policy, the claim is approved for payment.

A number of claims may require medical clarification before a final decision can be made. In such cases and depending on the particular circumstances involved, the claim examiner may possibly contact the attending physician for a further and more detailed explanation of the employee's condition. The claim examiner may obtain an independent opinion of a medical specialist. In such cases, the specialist is telephoned by the examiner and given a brief summary of the claimant's condition. At the same time arrangements are made for an examination of the claimant, usually at the physician's office. The appointment is confirmed by letter to the specialist and the claimant is also notified of our request for an examination by an impartial specialist and the appointment time and place is furnished the claimant.

Some claims involve a condition that is subjective in nature. In such cases, the claim examiner may wish to investigate the claimant's activities. Activity investigations are generally performed by outside mercantile agencies whose inspectors have substantial experience in this field.

Each claim is considered individually and approval or disallowal is based strictly on the merits of the particular claim. Since each claim has its own set of circumstances, the claim examiner may use one or more of the afore-mentioned methods to obtain the necessary information in order to fully and properly evaluate the claim. If the claim examiner has any question regarding the validity of the disability, the claim is reviewed by our Medical Director who will then decide on the disability, or indicate what additional information should be obtained.