

Fax to: Claims 1.800.880.9325
From: _____
Fax Number: _____
Date: _____
Number of pages: _____

Group Short-Term Disability Claim Form and Instructions



What can I do to avoid delays?

Missing information is one of the major causes of delay in processing. Please be sure:

- You **Sign** the Authorization (attached) and the Certification (below).
- Your employer and doctor complete their sections in full.
- You **Enclose** the information requested.
- You **Advise** your doctor we may be contacting him/her if additional information is needed.

When should I expect a reply?

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way. **Typical turnaround time is 21 calendar days from mailbox to mailbox.**

To avoid mail delays:

- **Fax** your claim to us at 1.800.880.9325. Please allow 48 hours for our automated service center to be updated with information confirming receipt of your fax, **or...**
- Have your payment returned by **overnight delivery** by initialing the Service Release below. A \$18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments over \$100.00. A street address is required. Your check will be delivered Monday through Friday; however, the time is not guaranteed.**

SERVICE RELEASE-Please initial below as indicated.

_____ (initial)	I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by discussing its details with a local sales representative if he/she is inquiring on my behalf.
_____ (initial)	I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by discussing its details with my plan administrator if he/she is inquiring on my behalf.
_____ (initial)	I authorize Colonial Life & Accident Insurance Company to communicate information (other than medical) or the status of this claim through electronic messaging at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine.
_____ (initial)	Yes, please deduct the \$18 fee (cost subject to rate increases) to overnight any applicable benefits from my claim payment for this claim. I understand this fee will be deducted for future payments for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under \$100.00 will be sent by regular mail.

Colonial Life, 1200 Colonial Life Boulevard, Columbia, South Carolina 29210
coloniallife.com

Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others require the following statement to appear on this claim form.

Fraud Warning : Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Arizona Residents : For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California, Rhode Island, Texas and West Virginia Residents : For your protection, California, Rhode Island, Texas and West Virginia law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents : It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Florida Residents : Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky : For your protection, Kentucky law requires the following to appear on this form: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington Residents : It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New York Residents : Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania Residents : Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oregon Residents : Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Puerto Rico Residents : Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

INSTRUCTIONS: Missing information is one of the major causes of delay in processing. **Please be sure to complete Section I in full and attach any documents requested.**

After completing Section I, please have your employer complete Section II. Then, have your doctor complete Section III in full. Please mail or fax **all three sections** of the form to our office. If any additional information is needed, we will promptly notify you.

SECTION I - To be completed by insured/claimant

1. Insured's Name _____ <small>(First) (MI) (Last)</small>		Social Security Number _____	
2. Address: _____ <small>(Street)</small>		3. Home Phone Number _____	
_____		4. Work Phone Number _____	
_____		5. Email Address _____	
_____		6. Date of Birth _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <small>(City) (State) (Zip) (MM/DD/YYYY)</small>	
7. Date total disability began (MM/DD/YYYY)		8. Condition causing disability	
9. Was your condition caused by an accidental injury? <input type="checkbox"/> yes <input type="checkbox"/> no (If auto accident, attach copy of traffic report.)			
10. Tell us exactly how your injury happened: _____			

11. Date of injury (MM/DD/YYYY)		Time of injury	Place of Injury
12. Is your injury or illness related to your job? <input type="checkbox"/> yes <input type="checkbox"/> no		13. Have you filed for Workers' Compensation benefits? <input type="checkbox"/> yes <input type="checkbox"/> no (If no, skip to #15.)	
14. Name of Workers' Compensation carrier		WC Phone #	
15. List your primary care doctor _____ <small>(Name) (Address) (Phone Number)</small>			
16. List all doctors or specialists who have treated you for this period of disability:			
Name	Address	Phone #	Fax #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
17. List the pharmacy where you regularly have prescriptions filled			Phone #
18. Did your injury/illness require hospital confinement? <input type="checkbox"/> yes <input type="checkbox"/> no Date Admitted (MM/DD/YYYY) _____ Date Discharged (MM/DD/YYYY) _____			
Name of Hospital _____		Phone # _____	
Address _____			
19. Dates unable to work: from (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____		21. If you have not returned to work, what is the estimated return to work date?	
20. Date returned to work: part-time MM/DD/YYYY _____ full-time MM/DD/YYYY _____			

CERTIFICATION

Policy owner Name _____ Social Security Number _____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct Social Security Number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page 2 of this form and that I read the statement required by the State department of Insurance for my state, if my state was listed on the form. **Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.**

Please remember to also sign and date the attached authorization required to process your claim.

X _____ **X** _____ / /
Claimant's Signature Policy owner's Signature Date (MM/DD/YYYY)

SECTION II - To be completed by Employer / Plan Administrator

Missing information is one of the major causes of delay in processing. **Please answer all questions in Section II and attach any specific documentation requested.** Providing **all** information requested on the claim form will help reduce the need to contact you for more information. It will also help us process your employee's claim more quickly. Please understand there may be situations that will still require us to contact you for additional clarification. We may also need to contact you for updates on the return to work status.

1. Name of Employee _____	2. Employee SSN _____
3. Group BCN _____	4. Employee's Coverage Effective Date (MM/DD/YYYY) _____
5. The employee's Social Security Number shown in Section I is correct. <input type="checkbox"/> yes <input type="checkbox"/> no	
6. Hire Date (MM/DD/YYYY) _____	7. Employee's Occupation _____ (attach a job description)

8. Hourly Rate of Pay _____ Hours worked per week _____ Basic Annual Salary _____
(for hourly employees) (for salaried employees)

(If employee is paid commissions, please attach a breakdown of commissions for the 12 months prior to disability.)

(If pay method is unusual - mileage, production-based, etc. - please attach a breakdown of weekly or monthly earnings for the 12 months prior to disability.)

9. Date last worked (MM/DD/YYYY) _____ Date sick leave was exhausted (MM/DD/YYYY) _____

10. If eligible for FMLA, list dates approved under FMLA: from (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

11. Date employment terminated (MM/DD/YYYY) _____ Reason _____

12. a) Was employee at work when the injury or illness occurred? yes no (If no, skip to #11.)
b) Is a Workers' Compensation claim being filed? yes no **(attach copy of First Report of Injury)**
c) Have WC benefits been paid? yes no Weekly Amt _____ Dates Paid (MM/DD/YYYY) _____
d) Name of WC carrier _____ Phone # _____

13. Date employee returned to work: part-time (MM/DD/YYYY) _____ full-time (MM/DD/YYYY) _____

(If disability periods have been sporadic, please attach copies of time sheets or attendance records to confirm all dates of disability)

14. Name of person to contact for updates on return to work status _____
Phone # _____ Fax # _____

Name of person completing form: _____ Title _____

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Signature: _____ Date (MM/DD/YYYY) _____

Address: _____ Phone # _____
(Street)

(City) (State) (Zip) Fax # _____

SECTION III – Attending Physician’s Statement – To Be Completed By Doctor

A. General Information

1. Patient's Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Social Security Number	
2. Patient's Birthdate ____/____/____	Height	Weight	Blood Pressure	ICD or DSM Code
3. Primary Diagnosis		Secondary Conditions/Complications		

B. Complete this section for normal pregnancy, then go to section E.

4. Expected Date of Delivery ____/____/____	Actual Date of Delivery ____/____/____	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	Date of first contact for this Pregnancy ____/____/____	What was the last date of treatment? ____/____/____
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C. Complete this section for all conditions except normal pregnancy.

5. Symptoms				
6. Objective Findings				
7. If this is a cardiac condition, what is the functional capacity? (American Heart Association)		<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Class 1 - No limitation <input type="checkbox"/> Class 2 - Slight limitation	<input type="checkbox"/> Class 3 - Marked limitation <input type="checkbox"/> Class 4 - Complete limitation
8. Date of new patient consultation ____/____/____	Name of Referring Physician		Physician's Telephone #	
9. When did symptoms first appear? ____/____/____	Date of patient's first visit ____/____/____	Date of patient's last visit ____/____/____	How often do you see the patient?	
10. Date you believe the patient was first unable to work. ____/____/____	Is the patient's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain.		
11. Has the patient undergone surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date. ____/____/____	Name of Procedure	CPT Code	<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient
12. Do you expect surgery to be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list type of surgery recommended and approximate date to be performed.			
13. What medication is the patient currently taking? (Please include dosage)		List any other recommended treatments and frequencies (PT, etc.)		
14. Have you referred the patient for other types of consultations? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list type of consultation.		Name of Specialist	
15. Has the patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of Hospital			
16. Dates of Confinement (MM/DD/YYYY) From Through	Address of Hospital:			

D. Information about the patient's inability to work. Briefly describe restrictions and limitations.

17. Restrictions (What the patient SHOULD NOT do)		
18. Limitations (What the patient CANNOT do)		
19. What is your prognosis for return to work? <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent	Estimated return to work date ____/____/____	Actual Date Released ____/____/____
20. Has patient achieved maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, how soon do you expect fundamental changes in the patient's medical condition? <input type="checkbox"/> 1 – 2 months. <input type="checkbox"/> 3 – 4 months. <input type="checkbox"/> 5 – 6 months. <input type="checkbox"/> more than 6 months.	
21. Give details concerning expected improvement or deterioration:		
22. Additional remarks:		

E. Signature

Name (Attending Physician) Print	Specialty	Telephone No. (include area code)	Fax No. (include area code)
Street Address		City or town	State
		Zip Code	

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Signature	Tax ID No.	Date (MM/DD/YYYY)
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Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

X _____ XXX-XX-_____
(Signature) (Social Security Number — last 4 digits) (Date of Birth)

(Printed name of individual subject to this disclosure) (Date Signed)

If applicable, I signed on behalf of the insured as _____(indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of legal representative) (Signature of legal representative) (Date Signed)

Authorization