Colonial Life

Disability Claim Form

Fax to: 1.866.887.6644
From:_____
Number of pages:_____

MAIL TO:
Attn: Disability Benefits
P.O. BOX 100195
COLUMBIA, SOUTH CAROLINA 29202-3195
Call Center 1.800.325.4368

Please be sure to send the following Information:

- ✓ A **fully** completed physician's section,
- ✓ A **fully** completed employer's section,
- ✓ A signed and dated authorization,
- ✓ Copies of any related bills – doctor, ambulance, emergency room, hospital, physical therapy, etc.

Fax this direction.

****Your Disability or Critical Illness claim must be filed within 12 months of your date of loss.**

OPTIONAL SERVICE RELEASE AGREEMENT – Please **initial** below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.
I authorize Colonial Life to facilitate processing this claim by releasing its details to the individual inquiring on my behalf. Leave blank if you do not want anyone accessing your claim information.
_____sales representative _____ plan administrator
_____spouse, family member or significant other:
_____I want Colonial Life to update me on the status of my claim through electronic messaging at my home phone number indicated on this form. Messages will be left with anyone that answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1.800.325.4368 into my phone.
_____Yes, I want **ALL** payment(s) for this claim sent by overnight delivery. I understand payment(s) under $100.00 cannot be sent overnight and a $22.00 fee, which is subject to rate increases by carrier and **does not include weekend delivery,** will be deducted from my claim payment(s). **We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

Section 1 TO BE COMPLETED BY POLICY OWNER		
Claimant name __Male __Female	**Birth Date**	**Claimant's Social Security Number**
Relationship to Policy Owner: ___ spouse ___ dependent ___self ____domestic partner		
Policy owner Name (First, Last)	**Birth Date**	**Social Security Number**
Mailing Address (Street or PO Box)		**(Apartment/Unit/Lot number)**
(City) (State) (Zip)		**Home telephone number**
Policy owner e-mail address		**Work telephone number**
Claim is for: ____Accident _____Sickness	**Condition that keeps you from working**	
Date the accident occurred (not when it was treated)	**Have you been treated for the same or similar condition prior to this occurrence? ___Yes ___No If yes, when?**	
Description of accident (if auto accident, attach a copy of the traffic report)		

Were you at work at the time of your accident or sickness? ____Yes ____No	Have you filed for Workers' Compensation benefits? ____Yes ____No
Dates unable to work: From To	
If not employed, list dates of house confinement: From_____ To_____ (MM/DD/YYYY) (MM/DD/YYYY)	House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.
Have you been unable to perform any activities of daily living? ___Yes ___No If yes, please list the dates you were unable to perform the activities: From To Check the activities that you are unable to perform: __dressing __eating __meal preparation __toileting __continence __ bathing __ transferring	
Date returned to work: Full-time Part-time /Hours worked per week_____	

List all doctors who have treated you for this condition and include your primary doctor's name first.		
Doctor's name	Phone Number	Address
1.		
2.		
3.		
4.		

Were you hospital confined? ___Yes ___No Admitted Discharged)	Hospital name/address/phone number
Please submit detailed billing if confined to a Hospital as well as an operative report, if surgery was performed.	

Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them. This is called an assignment. If you wish to assign your benefits, please send a signed written request.

If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

CERTIFICATION

Policy owner/Employee's Name_____ **Social Security** _____

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. **Fraud Warning: Any person 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.**

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

X_____ X_____ X_____

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

Section 2 TO BE COMPLETED BY EMPLOYER(S)

Employee name_____ SSN _____ Hire date_____ Average number of scheduled hours per week_____	Date last worked_____ (MM/DD/YYYY) Dates employee unable to work (Full-time) From_____ AM/PM To_____ AM/PM (MM/DD/YYYY) (MM/DD/YYYY)
Date sick leave was exhausted_____ (MM/DD/YYYY) Dates approved for FMLA (if eligible) From To ((Date employment terminated_ (M	Was employee at work when the accident or sickness occurred? ___Yes ___No Is a Workers' Compensation claim being filed? ___Yes ___No Name and phone number of Workers' Compensation carrier:
For hourly employees: Hourly rate of pay_____ Hours worked per week_____	For salaried employees: Annual salary_____

If salary includes commissions, attach a breakdown commissions for the twelve months prior to date last worked.

Date returned to work: Full-time_____ (MM/DD/YYYY) Part-time_____/Hours per week_____ (MM/DD/YYYY)	Expected return to work

Employee's job title:

Employee's duties include:

Lifting	☐	Less than 15 lbs.	☐	15 to 44 lbs.	☐ over 45 lbs.
Stooping/bending	☐	none	☐	seldom	☐ frequent
Crawling/kneeling	☐	none	☐	seldom	☐ frequent
Reaching/pulling/pushing	☐	none	☐	seldom	☐ frequent
Repetitive motion	☐	none	☐	seldom	☐ frequent
Management Duties	☐	none	☐	seldom	☐ frequent

Sitting (number of hours each day):_____ Standing (number of hours each day)_____

Walking (number of hours each day):_____ Climbing Stairs/Ladders (number of hours each day)_____

Who should we contact for updates on return to work status? Name/Phone/Email

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.

Signed by_____ Title_____

Print name _____ Date_____
(MM/DD/YYYY)

Telephone Number( )_____ Fax Number( )_____

Email Address:

Section 3 TO BE COMPLETED BY PHYSICIAN		
Patient's name	Patient's DOB	Social Security Number
What primary condition prevents the patient from working?		
Symptoms:	Objective Findings:	
When did symptoms first appear?	Date of new patient consultation	If pregnancy, what is EDC?
Is condition due to accident? ____Yes ____No If yes, date and description of accident.		
Are any secondary conditions preventing the patient from working?___Yes ___No	If yes, what are these secondary conditions?	
Please list all dates of treatment patient received medical advice, diagnosis or treatment including prescription medication for this condition or a related condition for the 18 months prior to this disability to the present.		
List any test(s) performed and submit a copy of the results.	List any surgeries performed with the date and procedure code.(CPT) (Attach a copy of the operative report)	
Restrictions (What the patient SHOULD NOT DO)		
Limitations (What the patient CANNOT DO)		
How soon do you expect significant improvement in the patient's medical condition? _____1-2 months _____3-4 months _____5-6 months _____more than 6 months		Expected return to work
Dates unable to work (full-time): From To	Dates unable to work (part-time): From To:	Actual date released to return to work
Does this patient have permanent restrictions/limitations? ___Yes ___No	If not employed, list dates of house confinement: From To	House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.
Please check the activities of daily living that the patient is unable to perform: __dressing __eating __meal preparation __toileting __continence __bathing __transferring		
Have you referred patient for other types of consultations? _____Yes _____No	How often do you see the patient?	
Name and Address of Hospital	Name and address of Specialist	
Dates of Hospitalization (Last 3 months)		

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Signature of Physician	Date_____ (MM/DD/YYYY)	Physician's Specialty
Telephone number	Fax Number	Tax ID or SSN
Physician/Group Name		Patient Account Number
Mailing Address		Do you accept Medical Records request by Fax? Yes No
Was patient referred to you by another physician? _____Yes _____No		Do you have authorization on file to release information to Colonial Life? Yes No
Provide the following information for referring doctor. Name:		Phone number
Address		Fax number

Phone 1.800.325.4368 **Fax 1.800.880.9325**

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 re-disclose the information unless permitted or required by those laws. Re-disclosed information may no longer be protected by federal privacy 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 No# — last 4 digits) (Date of Birth)

X_____ _____

(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.

X_____ X_____ _____

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