

Fax to: Claims 1.866.887.6644

From: _____ Number of pages: _____

Continuing Disability Claim Form

MAIL TO: COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

Attn: Disability Benefits

P.O. BOX 100195

Columbia SC 29210

COLUMBIA, SOUTH CAROLINA 29209-3195

Questions? Call 1.800.325.4368 • 24 Hours A Day / 7 Days a Week



Fax this direction.



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

Policy owner (First, Last)	Birth Date	Social Security Number
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Mailing Address (Street or PO Box)	Apartment number
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(City)	(State)	(Zip)	Home telephone
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Policy owner e-mail address	Work telephone
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Claimant name <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Claimant Social Security Number
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Claim is for: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness	Condition that keeps you from working
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Date the accident occurred (not when it was treated)	Description of accident
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Were you at work at the time of your accident or sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates unable to work: From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)
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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.
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Date you returned to work: Full-time _____ Part-time _____/Hours worked per week _____ (MM/DD/YYYY) (MM/DD/YYYY)

SECTION 2 TO BE COMPLETED BY EMPLOYER

Dates Employee unable to work (Full-Time): From _____ AM/PM To _____ AM/PM (MM/DD/YYYY) (MM/DD/YYYY)	Was employee at work when the accident or sickness occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date returned to work: Full-time _____ AM/PM Part-time _____ AM/PM/Hours per week _____ (MM/DD/YYYY) (MM/DD/YYYY)	Employee's Job Title
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Expected return to work _____ (MM/DD/YYYY)	Who should we contact for updates on return to work status? Name/Phone/Email
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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.

Employer Name (print) _____ Signed by _____

Title _____ Date _____
(MM/DD/YYYY)

Employer's Email Address _____

Employer's Telephone Number () _____ Employer's Fax Number () _____

Policy Owner Name _____ Policy Owner Social Security Number _____

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.

Policy Owner

Policy Owner Social Security Number



SECTION 3

TO BE COMPLETED BY PHYSICIAN

Fax this direction.

Patient's Name

Patient's DOB

What primary condition prevents the patient from working?

Symptoms:

Objective Findings:

Date first treated for this condition ____/____/____ (MM/DD/YYYY)

If pregnancy, what is EDC? ____/____/____ (MM/DD/YYYY)

Is condition due to accident? Yes No

If yes, date and description of accident ____/____/____ (MM/DD/YYYY)

Are any secondary conditions preventing the patient from working?

Yes No

If yes, what are these secondary conditions?

When did symptoms first appear?

____/____/____ (MM/DD/YYYY)

Date of new patient consultation

____/____/____ (MM/DD/YYYY)

Date of patient's last visit

____/____/____ (MM/DD/YYYY)

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

Estimated Return to Work Date

(MM/DD/YYYY)

Dates (MM/DD/YYYY) unable to work full-time

From: To:

Dates (MM/DD/YYYY) unable to work part-time

From: To:

Actual date released to return to work.

____/____/____ (MM/DD/YYYY)

Does this patient have permanent restrictions/limitations?

Yes No

If not employed, list dates of house confinement:

From ____ (MM/DD/YYYY) To ____ (MM/DD/YYYY)

House Confinement means you are have 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

Dates (MM/DD/YYYY) of Office visits (Last 3 months)

How often do you see the patient?

Have you referred patient for other types of consultation

Yes No

Name and address of Specialist

Dates (MM/DD/YYYY) of Hospitalization (Last 3 months)

Name and Address of Hospital

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 Attending Physician portions of the claim form.

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

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 _____
Claimant's Signature

X _____
Policy owner's Signature

____/____/____
Date (MM/DD/YYYY)