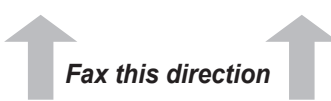


Fax to: Claims 1.866.887.6644

From: \_\_\_\_\_ Number of pages: \_\_\_\_\_



# Disability Claim Form

**MAIL TO: COLONIAL LIFE & ACCIDENT INSURANCE COMPANY**  
**Attn: Disability Benefits**  
**P.O. BOX 100195**  
**Columbia SC 29202**  
Questions? Call **1.800.325.4368** • 24 Hours A Day / 7 Days a Week

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.

**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 an \$18.00 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)*

<b>Section 1</b>				<b>TO BE COMPLETED BY POLICY OWNER</b>	
Claimant name _____ Male _____ Female	Birth Date _____	Claimant Social Security Number _____			
Relationship to Policy Owner _____ spouse _____ dependent _____ self _____ domestic partner					
Policy owner (First, Last) _____	Birth Date _____	Social Security Number _____			
Mailing Address (Street or PO Box) _____				Apartment/Unit/Lot Number _____	
(City) _____	(State) _____	(Zip) _____	Home Telephone ( ) _____		
Policy Owner e-mail address ( <i>*Please print</i> ) _____				Work Telephone ( ) _____	
Claim is for: _____ Accident _____ Sickness			Condition(s) that keeps you from working _____		
Date the accident occurred (not when it was treated) _____ <small>(MM/DD/YYYY)</small>				Have you been treated for the same or similar condition prior to this occurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ <small>(MM/DD/YYYY)</small>	
Check One: _____ On-Job _____ Off-Job					
Description of accident (if auto accident, attach a copy of the traffic report)					

## 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.



**CERTIFICATION**

Policy owner/Employee's 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

X \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (MM/DD/YYYY)

**Section 1 ...continued TO BE COMPLETED BY POLICY OWNER**

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 \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

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 \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

Check the activities that you are unable to perform:

dressing  eating  meal preparation  toileting  continence  bathing  transferring

Date you returned to work: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_/Hours worked per week \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

List all doctors who have treated you for this condition and include your primary doctor's name first.

Doctor's name	Phone Number	Fax Number	Address
1.			
2.			
3.			
4.			

Were you hospital confined?  Yes  No

Hospital name/address/phone number

Admitted \_\_\_\_\_ Discharged \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

*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.**



**SECTION 2 TO BE COMPLETED BY EMPLOYER**

Employee name \_\_\_\_\_

Date last worked \_\_\_\_\_  
(MM/DD/YYYY)

Hire date \_\_\_\_\_

Dates employee unable to work (Full-time)  
From \_\_\_\_\_ AM/PM To \_\_\_\_\_ AM/PM  
(MM/DD/YYYY) (MM/DD/YYYY)

Average number of scheduled hours per week \_\_\_\_\_

Date sick leave was exhausted \_\_\_\_\_  
(MM/DD/YYYY)

Was employee at work when the accident or sickness occurred?  
 Yes  No

Dates approved for FMLA (if eligible)

Is a Workers' Compensation claim being filed?  
 Yes  No

From \_\_\_\_\_ To \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

Date employment terminated \_\_\_\_\_  
(MM/DD/YYYY)

Name of Workers' Compensation carrier: \_\_\_\_\_

Phone number \_\_\_\_\_

For hourly employees:

For salaried employees:

Hourly rate of pay \_\_\_\_\_ Hours worked per week \_\_\_\_\_

Annual salary \_\_\_\_\_

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

Date returned to work: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_/Hours per week \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

If not returned, expected return to work  
\_\_\_\_\_  
(MM/DD/YYYY)

Is light duty work available?  Yes  No

Employee's job title: \_\_\_\_\_

Employee's duties include:

Lifting	<input type="checkbox"/> Less than 15 lbs.	<input type="checkbox"/> 15 to 44 lbs.	<input type="checkbox"/> over 45lbs.
Stooping/bending	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Crawling/kneeling	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Reaching/pulling/pushing	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Repetitive motion	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Management Duties	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> 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? (*\*Please print*)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

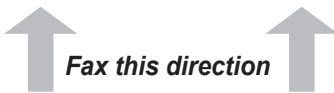
**FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.**

Signed by \_\_\_\_\_ Title \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_  
(MM/DD/YYYY)

Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

E-mail Address (*\*Please print*) \_\_\_\_\_

**SECTION 3****TO BE COMPLETED BY PHYSICIAN**

Patient's Name	Patient's DOB
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date and description of accident ____/____/____ (MM/DD/YYYY)
----------------------------------------------------------------------------------------	----------------------------------------------------------------------

Are any secondary conditions preventing the patient from working? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <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	Estimated Return to Work Date ____/____/____ (MM/DD/YYYY)
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

Dates (MMDD/YYYY) unable to work full-time From: _____ To: _____	Dates (MMDD/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? <input type="checkbox"/> Yes <input type="checkbox"/> No	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.
------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Please check the activities of daily living that the patient is unable to perform:  
 dressing  eating  meal preparation  toileting  continence  bathing  transferring

Dates (MMDD/YYYY) of Office Visits (Last 3 months)	How often do you see the patient?
----------------------------------------------------	-----------------------------------

Have you referred patient for other types of consultation <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of Specialist
-----------------------------------------------------------------------------------------------------------------------	--------------------------------

Dates (MMDD/YYYY) of Hospitalization (Last 3 months)	Name and Address of Hospital
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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.**

Physician/Group Name	Date (MMDD/YYYY)	Tax ID
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Telephone Number ( )	Fax Number ( )	Physician's Specialty
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Signature of Physician	Patient Account Number
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Mailing Address	Do you accept Medical Records request by Fax? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Was patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an authorization on file to release information to Colonial Life? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Provide the following information for referring doctor: Name:	Phone number
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Address	Fax number
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