

# Disability CLAIM FORM



**Instructions — complete this form after you become disabled.**

- 1) You will complete page 1, "Employee's Statement" and "Authorization" sections.
- 2) If applying for Long Term Disability benefits, you must also complete and attach the: LTD Payment Options form, HIPAA Authorization form, and, Medical History form.
- 2) Then, your doctor is to complete pages 3 and 4, the "Attending Physician's" section.
- 3) Finally, forward the form to your employer to complete page 2, the "Employer's Statement" section.
- 4) Mail or fax the completed forms to Advance Insurance Company of Kansas.

**Claim no. (for office use only)**

**What benefit are you applying for?**     Short term disability     Long term disability     Waiver of Premium

## Employee's Statement

1. Your full name: (Last) (First) (Middle)			2. Social Security No.		
3. Home address: (Street) (City) (State) (Zip)			4. Home phone No. ( ) ( )		
5. Date of Birth (MM-DD-YYYY)		6. Place of Birth		7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Occupation					
9. I have been unable to work due to this disability since: (MM-DD-YYYY)		10. I returned to work part-time on: (MM-DD-YYYY)		11. I returned to work full-time on: (MM-DD-YYYY)	
12. Is disability due to?: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness		13. Describe how and where accident occurred, or describe the first symptoms of your illness:			
14. Date of your accident or date you first noticed the symptoms of your illness: (MM-DD-YYYY)		15. Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. If yes, please explain:	
17. Date you were first treated for your illness or injury (MM-DD-YYYY)		18. Have you been hospitalized for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the dates of hospitalization, the name and address of the hospital, and, the name and address of the physician that treated you below: Dates of hospitalization: from (MM-DD-YYYY) through (MM-DD-YYYY) Hospital (Name) (Address) Physician (Name) (Address)			
19. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? (MM-DD-YYYY)					
20. Treating physician _____ Dr.'s phone no. ( ) _____ Dr.'s address _____					
21. What other income are you receiving, or are eligible for, as a result of this disability? (PIP or Personal Injury Protection under auto insurance, other employer-sponsored/payroll-deducted disability policy, Social Security, Worker's Compensation, etc.) Source of income                      Amount of income                      Date income began                      Date income ended _____					
<b>Please answer questions 22 through 25 only if you are applying for Long Term Disability (LTD) benefits.</b>					
22. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally separated		23. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		24. No. of children:	
25. Names and date of birth of spouse and children:					

**(your signature is required before any claim can be processed) Authorization**

The above statements are true and complete to the best of my knowledge and belief. I understand the furnishing of this form and its acceptance by the Company shall not be construed as an acknowledgment of any liability nor a waiver of any rights on the part of the Company. I hereby authorize any hospital or physician who has treated me, other person who has attended me, examined me, or any government agency to furnish to Advance Insurance Company of Kansas (AICK) providing this form, or their representatives, any and all information with respect to any illness, injury, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this authorization will be as valid as the original. I may revoke this authorization by notifying AICK in writing of my desire to do so. This authorization expires two years from the date signed.

Employee sign here X \_\_\_\_\_ Date signed \_\_\_\_\_

**— Warning —**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline (800) 530-5989.

**(to avoid delay, please answer all questions) Employer's Statement**

What benefit is the employee applying for?    Short term disability    Long term disability    Waiver of Premium

1. Employee's name:	2. Social Security No.	3. Policy No.
4. Employee's date of hire:	5. Employee's effective date of insurance:	
6. Date employee last physically reported to work:	7. Reason for stopping work?	
8. Occupation at the time of the disability:	9. Employee's work schedule: _____ days a week, _____ hours a day	
10. Employee's salary: \$ _____ per hour @ _____ (hours) per week What date did this salary go into effect? _____	11. Does the salary provided include the following (check all that apply): <input type="checkbox"/> Overtime <input type="checkbox"/> Bonuses <input type="checkbox"/> Commissions <input type="checkbox"/> Other (describe) _____	
12. What percentage of the premium does the <b>employee</b> pay for the benefit being applied for? _____	13. Is the premium for this benefit run through a Section 125 or Flexible Benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you answered yes, the disability benefits will be taxed at 100 percent for FICA taxes.)	
14. Employee returned to work part-time on: MM _____ DD _____ YYY _____	15. Employee returned to work full-time on: MM _____ DD _____ YYY _____	
16. Did this employee receive salary continuance, such as vacation or sick pay, anytime during this disability period? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date it began _____ through _____ Amount received: \$ _____ per _____	
17. Is this employee eligible for Worker's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Carrier _____	If yes, date it began _____ through _____ Amount received: \$ _____ per _____	
18. Will (or has) employee file(d) for unemployment compensation for disability benefits provided by an Employer-Employee, Labor Management or Union Welfare Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify _____	
19. Is this employee applying for or receiving benefits from any other employer-sponsored/payroll-deducted policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date it began _____ through _____ Amount received: \$ _____ per _____	
20. Is this employee eligible for pension disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date it began _____ through _____ Amount received: \$ _____ per _____	
21. Is your company subject to ERISA guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22. If applying for LTD benefits, please attach a job description for this employee that includes the physical requirements of the job.		
23. Remarks _____ _____		

**Please print clearly. A signature is required before any claim can be processed.**

Name of Group Policyholder _____
Full address _____ <small>(PO Box and Street, City, State and Zip)</small>
Phone no. (     ) _____ Fax no. (     ) _____
Employer sign here <u>X</u> _____ Date signed _____
Title of signatory above _____

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**(to avoid delay, please answer all questions) Attending Physician's Statement**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(MM-DD-YYYY)

**1. History**

- a) When did the symptoms first appear or accident happen? MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_
- b) Date the patient ceased work because of this disability? MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_
- c) Has the patient ever had the same or a similar condition?  Yes  No If yes, when? And describe:  
\_\_\_\_\_
- d) Is condition due to an accident?  Yes  No If yes, indicate date of accident: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_
- e) Is condition due to injury or sickness arising out of the patient's employment?  Yes  No  Unknown
- f) Name and addresses of other treating physicians \_\_\_\_\_

**2. Disability**

- a) Diagnosis (including any complications) \_\_\_\_\_ ICD-9 Code \_\_\_\_\_
- b) Subjective symptoms \_\_\_\_\_ ICD-9 Code \_\_\_\_\_
- c) If disability is due to pregnancy, EDC \_\_\_\_\_ Delivery date \_\_\_\_\_ Type of Delivery \_\_\_\_\_

**3. Dates of Treatment**

- a) Date you **first** treated patient for this episode of disability: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_
- b) Date of most recent treatment: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_
- c) Frequency:  Weekly  Monthly  Other (specify): \_\_\_\_\_
- d) Date of next scheduled visit: MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_

**4. Nature of Treatment**

- a) Treatment prescribed (including surgery, medication, physiotherapy, etc.): \_\_\_\_\_ ICD-9 Code \_\_\_\_\_
- b) To your knowledge, is the patient following the recommended treatment program?  Yes  No

**5. Progress**

- a) Has patient  Recovered?  Improved?  Unchanged?  Retrogressed?
- b) Is patient  Ambulatory?  House confined?  Bed confined?  Hospital confined?
- c) Has patient been hospital confined?  Yes  No If yes, provide dates of confinement:  
confined from MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_ through MM \_\_\_\_\_ DD \_\_\_\_\_ YYYY \_\_\_\_\_  
Name and address of hospital \_\_\_\_\_

**6. Cardiac (if applicable) American Heart Association**

- a) Functional capacity:  Class 1-no limitation  Class 2 -slight limitation  Class 3-marked limitation  Class 4-complete limitation
- b) Blood pressure reading (last visit): Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

**7. Physical Impairment (which applies to your patient at time of disability?)**

- Class 1 - no limitation of functional capacity; capable of heavy work (No Restrictions).
- Class 2 – medium activity; capable of medium work.
- Class 3 – slight limitation of functional capability; capable of light work.
- Class 4 – moderate limitation of functional capacity; capable of clerical/administrative activity.
- Class 5 – severe limitation of functional capacity; incapable of even minimum sedentary work.

**continued, Attending Physician's Statement**

**Patient name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_  
(MM-DD-YYYY)

**8. Mental/Nervous Impairment (if applicable)**

- Class 1 – patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2 – patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- Class 3 – patient is able to engage only in limited stress situations and only limited interpersonal relations (moderate limitations).
- Class 4 – patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- Class 5 – patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

**9. Status and Prognosis**

- |  |   |   |
|--|---|---|
|  | <b>Patient's job</b>  | <b>Any other work</b>   |
| a) Does this disability prevent this patient from working at:  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| b) What duties of patient's job is he/she unable to perform? _____                                     |   |   |
|  | <b>Patient's job</b>  | <b>Any other work</b>   |
| c) Do you expect a fundamental or marked change in the future?   | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| If yes, indicate date patient will recover sufficiently to perform duties? MM _____ DD _____ YYY _____ |   | MM _____ DD _____ YYY _____   |
| If no, please explain _____  |   |   |
|  | <b>Patient's job</b>  | <b>Any other work</b>   |
| d) Estimated recovery time for this disability: _____ (No. of weeks) or                                | <input type="checkbox"/> 1 mo <input type="checkbox"/> 2-3 mo<br><input type="checkbox"/> 4-6 mo <input type="checkbox"/> Never | <input type="checkbox"/> 1 mo <input type="checkbox"/> 2-3 mo<br><input type="checkbox"/> 4-6 mo <input type="checkbox"/> Never |

**10. Rehabilitation**

- |  |  |  |
|--|--|--|
|  | <b>Patient's job</b>                                     | <b>Any other work</b>                                    |
| a) Is patient a suitable candidate for further rehabilitation services?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Can present job be modified to allow for handling with impairment?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| c) When could trial employment commence? <input type="checkbox"/> full-time <input type="checkbox"/> part-time | MM _____ DD _____ YYY _____                              | MM _____ DD _____ YYY _____                              |
| d) Would vocational counseling and/or retraining be recommended?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**11. Remarks**

\_\_\_\_\_  
 \_\_\_\_\_

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Physician's full name \_\_\_\_\_ Specialty \_\_\_\_\_  
 Full address \_\_\_\_\_  
(PO Box and Street, City, State and Zip)  
 Phone no. (    ) \_\_\_\_\_ Fax no. (    ) \_\_\_\_\_  
 Physician sign here *X* \_\_\_\_\_ Date signed \_\_\_\_\_

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