Disability Claim Form

ADVANCE Insurance Company of Kansas℠

The instructions:
1. Pages 1 and 2 are to be completed by you, the employee;
2. Page 3 must be completed by the Group Policyholder (your employer); and,
3. Pages 4 and 5 must be completed by the doctor that advised you to stop working.
4. Fax or mail the completed forms to Advance Insurance Company of Kansas.

For office use only

Claim number

Employee's statement

CLEAR DATA

Benefit being requested:

☐ Short term disability ☐ Long term disability ☐ Waiver of premium

Your first name | MI | Last name | Suffix | Gender: ☐ Male ☐ Female | Your date of birth

Your home address | City | State | ZIP code

Social security no. | Your home phone number | Your occupation

1) Is this disability due to: ☐ an Accident ☐ a Sickness?

2) I have been unable to work due to this disability since (what date?): ____ ____ ____

3) I returned to work (check one): ☐ part-time on (what date?): ____ ____ ____
☐ full-time on (what date?): ____ ____ ____

4) What was the date of your accident or that you first noticed the symptoms of your sickness? ____ ____ ____

5) Describe how and where the accident occurred or describe the first symptoms of your sickness:

6) Is your accident or sickness related to your occupation? ☐ Yes ☐ No If yes, please explain:

7) What date were you first treated for your injury or sickness? ____ ____ ____

8) Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, when? ____ ____ ____

9) Have you been hospitalized for this disability? ☐ Yes ☐ No If yes, provide the information requested below about your stay:

a) Dates of hospitalization: from ____ ____ ____ to ____ ____ ____

b) Hospital: Name | Street or PO Box | City | State | Zip code

c) Physician: Name | Street or PO Box | City | State | Zip code

10) Name of physician treating you for this disability:

a) Your treating physician's phone number: ____ ____ ____

b) Your treating physician's address: Street or PO Box | City | State | Zip code

Please continue the employee's statement on page 2.

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Employee's statement continued

11) What other income are you receiving? (include any form of employment) What other income are you eligible for as a result of this disability? (e.g., Personal Injury Protection under auto insurance, other employer-sponsored/payroll-deducted disability policy, Social Security, Worker's Comp, Unemployment Benefits, etc.):

☐ No other source of income

☐ I am receiving other income which is explained below:

a) Source of income: _____ Amount: _____

b) Date other income began and ended: from ____ ____ _____ to ____ ____ _____

12) Marital status: ☐ Married ☐ Single ☐ Legally separated

a) If married, is your spouse employed? ☐ Yes ☐ No

b) How many children do you have?_____

13) List the names and dates of birth for your spouse and dependent children (if you need more space, attach a separate sheet with complete information; and, sign and date the separate sheet):

Name	Date of birth	Relationship

Authorization

The statements above are true and complete to the best of my knowledge and belief. I understand the Company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form and investigating the claim.

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 the authorization by notifying AICK in writing of my desire to do so. This authorization expires two years from the date signed.

_____ ____ ____ _____

Employee sign here Date signed

Employer's statement (answer all questions to avoid delay)

Benefit being requested:

☐ Short term disability ☐ Long term disability ☐ Waiver of premium

Employee's first name MI Last name Suffix Social security no.

Employee's date of hire Employee's effective date of insurance

1) Employee's work schedule _____ days a week; _____ hours a day
2) What was the employee's occupation at the time of the disability? _____
3) What date did the employee last physically report to work? _____ _____ _____
4) What was the reason for stopping work? _____
5) Employee's salary: $_____ per hour @_____ hours per week as of _____ _____ _____ Date salary went into effect
6) Does the salary provided include the following (check all that apply): ☐ Overtime ☐ Bonuses ☐ Commissions
7) What percentage of the premium does this **employee** pay for the benefit being applied for? _____%
8) Is the premium for this benefit run through a Section 125 or Flexible Benefit plan? ☐ Yes ☐ No (Notice: if you answered yes, the disability benefits will be taxed at 100 percent for FICA taxes.)

9) Employee returned to work: part-time on (what date?): _____ _____ _____
full-time on (what date?): _____ _____ _____
10) Will (or has) employee receive(d) salary continuance, such as vacation pay, sick pay, or PTO, anytime during this disability period? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ _____ _____ through _____ _____ _____
11) Will (or has) employee apply(ied) for Worker's Compensation? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ _____ _____ through _____ _____ _____ and amount received: $ _____ per _____
12) Will (or has) employee file(d) for unemployment compensation for disability benefits provided by an Employer-Employee Labor Management of Union Welfare Plan? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ _____ _____ through _____ _____ _____ and amount received: $ _____ per _____
13) Is this employee applying for or receiving benefits from any other employer-sponsored/payroll-deducted policy? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ _____ _____ through _____ _____ _____
14) Is this employee eligible for pension disability? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ _____ _____ through _____ _____ _____ and amount received: $ _____ per _____

15) Is your company subject to ERISA guidelines? ☐ Yes ☐ No
16) If applying for Long Term Disability benefits, please attach a job description for this employee that includes the physical requirements of the job.
17) Remarks: _____

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

Name of Group Policyholder Phone no. Fax no.

Employer's full address City State ZIP code

Employer sign here Title of signatory Date signed

Attending physician's statement (to be completed only by the treating physician or their staff member at the physician's direction. Please answer all questions to avoid delay).

Patient's first name _____ MI _____ Last name _____ Suffix _____ Date of birth _____ _____ _____

1) History

a) When did the accident occur or the symptoms of sickness first appear? _____

b) On what date did the physician tell the patient to cease work because of this disability? _____ _____ _____

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 the date of the accident: _____ _____ _____

e) Is condition due to an injury or sickness arising out of the patient's employment? ☐ Yes ☐ No ☐ Unknown

f) Name(s) and adress(es) of other treating physicians: _____

_____

2) Disability

a) Diagnosis (including any complications)? _____ ICD-10 code _____

b) Subjective symptoms? _____ ICD-10 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: _____ _____ _____

b) Date of most recent treatment: _____ _____ _____

c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

d) Date of next scheduled visit: _____ _____ _____

4) Nature of treatment

a) Treatment prescribed (including surgery, medication, physiotherapy, etc.): CPT 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 ☐ Hospital confined

c) Has patient been hospital confined? ☐ Yes ☐ No If yes, provide dates of confinement:

a) Dates of hospitalization: from _____ _____ _____ to _____ _____ _____

b) Hospital: _____

Name Street or PO Box City State Zip code

6) Cardiac (if applicable) American Heart Association

a) Functional capacity: ☐ Class 1 - no limitation ☐ Class 3 - marked limitation
☐ Class 2 - slight limitation ☐ Class 4 - complete limitation

b) Blood pressure reading (last visit): Systolic _____ Diastolic _____

Attending physician's statement continued

Patient's first name | MI | Last name | Suffix | Date of birth

7) Physical impairment (which of these classes applies to your patient for **this** episode 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.

8) Mental/Nervouse 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 stressful situations and engage in most interpersonal relations (Slight limitations).
- ☐ Class 3 - patient is able to engage only in limited stressful situations and only limited interpersonal relations (Moderate limitations).
- ☐ Class 4 - patient is unable to engage in stressful 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

	Patient's job	**Any other work**
a) Does this disability prevent this patient from working at:	☐ Yes ☐ No	☐ Yes ☐ No
b) What duties of patient's job is he/she unable to perform? _____		
c) Do you expect a fundamental or marked change in the future:	☐ Yes ☐ No	☐ Yes ☐ No
If yes, indicate date patient will recover sufficiently to perform duties:	____ ____ _____	____ ____ _____
If no, please explain: _____		
d) Estimated recovery time for this disability: _____ (no. of weeks) or	☐ 1 month ☐ 2-3 months ☐ 4-6 months ☐ Never	☐ 1 month ☐ 2-3 months ☐ 4-6 months ☐ Never

10) Rehabilitation

	Patient's job	**Any other work**
a) Is patient a suitable candidate for further rehabilitation services?	☐ Yes ☐ No	☐ Yes ☐ No
b) Can present job be modified to allow for handling with impairment?	☐ Yes ☐ No	☐ Yes ☐ No
c) When could trial employment commence? ☐ full-time ☐ part-time	____ ____ _____	____ ____ _____
d) Would vocational counseling and/or retraining be recommended?	☐ Yes ☐ No	

11) Remarks _____

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

Physician's full name | Phone no. | Fax no.

Physician's full address | City | State | ZIP code

Physician's specialty

Physician sign here | Date signed