

Disability Claim Form



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

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.

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 _____

Name _____ Date of birth _____ Relationship _____

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.): _____ ICD-10 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 2 - slight limitation Class 3 - marked 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

a) Does this disability prevent this patient from working at: **Patient's job**
 Yes No **Any other work**
 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: **Patient's job**
 Yes No **Any other work**
 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 **Patient's job**
 1 month
 2-3 months
 4-6 months
 Never **Any other work**
 1 month
 2-3 months
 4-6 months
 Never

10) Rehabilitation

a) Is patient a suitable candidate for further rehabilitation services? **Patient's job**
 Yes No **Any other work**
 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 _____