



**HOW TO FILE A CLAIM**  
**for**  
**SHORT TERM DISABILITY**

**Claim payment may be delayed if information is incomplete or missing.**

**Part One (Page 1)** – To be completed by the Employer. Please note that employer signature, date and employee’s salary information are required.

**Part Two (Page 2)** – To be completed by Employee. Employee signature and date are required.

**Part Three (Page 3)** – To be completed by the Physician treating the employee for the illness/injury associated with the disability. Physician signature and date are required.

**Checklist to make sure all information required has been enclosed:**

\_\_\_\_\_ **Part One of the claim form is complete, signed, and dated.**

\_\_\_\_\_ **Part Two of the claim form is complete, signed, and dated.**

\_\_\_\_\_ **Part Three of the claim form is complete, signed, and dated.**

**PLEASE NOTE**

**Medical premiums will not be deducted from your short-term disability payments. You must make arrangements to pay your medical premiums in order to maintain your medical coverage.**

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**Questions?** Call Flexible StaffCARE’s toll-free Customer Service Line, 1-844-262-6027, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.





# Short-Term Disability/ Proof of Loss Form

Mail to: PAI, P.O. Box 6702, Columbia, SC 29260-6702

Claims payment may be delayed if information is incomplete or missing.

## Part One: Employer Completes This Section

Employer's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

Employer's Telephone No.: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_

Employee's Name: \_\_\_\_\_ Employee's SSN: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State ZIP

Home Telephone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:  Male  Female

Date Hired: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

Base Earnings: Monthly \$ \_\_\_\_\_ Weekly \$ \_\_\_\_\_ Occupation: \_\_\_\_\_

Employee laid off prior to this illness?  Yes  No If yes, date: \_\_\_\_\_

Date employee first unable to work: \_\_\_\_\_ Date employee returned to work: \_\_\_\_\_

Was illness or injury due to patient's occupation?  Yes  No If yes, explain: \_\_\_\_\_

I hereby certify that the above named employee is a member of our group insurance program and the information stated above is correct to the best of my knowledge and belief.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## Part Two: Employee Completes This Section

Employee's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First Middle

Date of First Treatment (Illness): \_\_\_\_\_ Date of Accident (Injury): \_\_\_\_\_ If accident, how did it occur? \_\_\_\_\_

Did accident occur at work?  Yes  No Date first unable to work: \_\_\_\_\_

Did patient have same or similar condition in past?  Yes  No If yes, when? List name and address of attending physician. \_\_\_\_\_

Remarks: \_\_\_\_\_

**Authorization Instructions:** The authorization should be completed and signed by the insured. If the insured is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a

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Underwritten by Fidelity Security Life Insurance Company  
Kansas City, Missouri

7-10-2019



We make Benefits Better.  
Administered by Planned Administrators Inc.  
Columbia, South Carolina



# Short-Term Disability/ Proof of Loss Form

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photographic copy of this authorization shall be as valid as the original.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to insured if signed by other than insured. \_\_\_\_\_

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

Name \_\_\_\_\_

Address \_\_\_\_\_

### Part Three: Attending Physician's Statement (Medical records attached? Yes No)

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State ZIP

**Authorization to Release Information:** I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signed (Patient): \_\_\_\_\_ Date: \_\_\_\_\_

1) a. Diagnosis –ICD9 Code: \_\_\_\_\_ and concurrent condition description \_\_\_\_\_  
If fracture or dislocation, describe nature and location. \_\_\_\_\_

b. Is condition due to injury or sickness arising out of patient's employment?  Yes  No If yes, explain: \_\_\_\_\_

c. Is condition pregnancy?  Yes  No If yes, what was the approximate date of commencement of pregnancy? \_\_\_\_\_  
Type of delivery: \_\_\_\_\_

2) a. When did symptoms first appear or accident happen? Date: \_\_\_\_\_

b. When did patient first consult you for this condition? Date: \_\_\_\_\_

c. Has patient ever had same or similar condition?  Yes  No If yes, state when and describe. \_\_\_\_\_

3) a. Nature of surgical or obstetrical procedure, if any. \_\_\_\_\_  
Date performed: \_\_\_\_\_  Inpatient  Outpatient Describe fully and include current CPT-4 codes: \_\_\_\_\_

b. If performed in a hospital, give name of hospital and dates hospitalized. \_\_\_\_\_

4) Give dates of other medical (non-surgical) treatment, if any. \_\_\_\_\_

5) Is patient still under your care for this condition?  Yes  No If no, give date your services terminated: \_\_\_\_\_

6) a. How long was or will patient be continuously totally disabled? \_\_\_\_\_, 20\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_  
If unknown, please estimate anticipated recovery date. \_\_\_\_\_

b. Is this an extension of a previous disability claim?  Yes  No Previous date: \_\_\_\_\_  
If yes, provide new dates through which patient will be totally disabled. \_\_\_\_\_

7) To your knowledge, does patient have other health insurance or health plan coverage?  Yes  No If yes, identify: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Degree: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(Print) Last First Middle

Address: \_\_\_\_\_  
Street City State ZIP

Individual Practitioner's I.D. Number: \_\_\_\_\_

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## Fraud Notices

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** 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.

**Arkansas, Louisiana, Rhode Island, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California 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:** 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.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** 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:** 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.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

**Kentucky:** 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, Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** 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 \$5,000 and the stated value of the claim for each violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:** 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.

**Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**All Other States:** Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.

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Kansas City, Missouri

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Columbia, South Carolina