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.

Questions? Call Benefits 4 Today's toll-free Customer Service Line, 1-800-440-3068, 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

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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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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: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive 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. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a 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, Idaho, Indiana and Oklahoma: 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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

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: 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.

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 RSA 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 five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All Other States Not Listed Separately: 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 fines and confinement in prison.

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