

Disability Claim Form and Instructions

If you have any questions about completing this form, call us at 800-392-9742
7:00 A.M. to 5:30 P.M. Central Standard Time.

INSTRUCTIONS FOR FILING CLAIM FOR DISABILITY

- Include your policy number. To obtain your policy number call 800-392-9742.
- **Sections 1, 2 and 3** should be completed and signed by claimant.
- **Section 4** should be completed and signed by your employer. If you are self-employed, also send us a copy of your current business license and your most recent quarterly tax records. Additional information may be required.
- **Section 5** should be completed and signed by your doctor.
- You may fax your claim to us at **608-373-9503**.
- You may mail your claim to:

Assurant Health
P.O. Box 2829
Clinton, IA 52733-2829
- Additional claim forms are available at www.voluntarymart.com.

SECTION 1: Claimant's Information			Policyowner's Information		
Last	First	MI	Last	First	MI
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed	Birth Date ____/____/____	Address	Birth Date ____/____/____	
Relationship to Policyowner: <input type="checkbox"/> Spouse <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Self			City	State	Zip
Social Sec. No.	Phone No.		Policy No.	Social Sec. No.	Phone No.
			<input type="checkbox"/> Check if new address		

SECTION 2: Policyowner's Statement (To avoid delay, all questions must be answered)

Name of Employer		Employer's Phone Number	
Employer's Address		City	State ZIP
Your Occupation & Title		List essential duties of your job at the time of disability	
How many hours were you regularly working per week prior to the disability with your present employer? _____ hrs.		Gross annual salary: (During the 12 months just prior to your disability - for this employer only) \$_____	
Date of injury or date first noticed symptoms of sickness: _____/_____/_____	You have been unable to work because of disability since: _____/_____/_____	You returned to work on a part-time basis on: _____/_____/_____	You returned to work on a full-time basis on: _____/_____/_____
Is your injury or sickness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", explain:		Did you file for workers' compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If auto accident, was the claimant: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger Include a copy of the incident or police report if applicable.	Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms. If more space is needed, please attach sheet of paper or additional documentation.		
Date first treated: _____/_____/_____	If "Hospital Confined", give name and address of hospital Hospital: _____ Name Street Address City State Zip Confined from ____/____/____ Through ____/____/____		
Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Treated by: Hospital: _____ Name Street Address City State Zip Doctor: _____ Name Street Address City State Zip		
For Pregnancy Disability Only: Are there any present complications or anticipated difficulties in connection with the following?			
a. Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last menstrual period: ____/____/____	Expected date of delivery: ____/____/____	
b. Delivery <input type="checkbox"/> Yes <input type="checkbox"/> No	Actual Date of Delivery: ____/____/____	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	
c. Post Partum <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes" to any of these, please specify in detail: _____			

Signature of Claimant _____

Date _____

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.

HIPAA AUTHORIZATION

Member Name: _____ Policy Number: _____

Claimant Name: _____ Date of Birth: _____

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested by Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including but not limited to, EMSI.

This authorization includes any and all information you have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Time Insurance Company, including but not limited to, EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as the original.

I understand that this authorization is required in order to enable Time Insurance Company to make payment determinations relating to me and/or my minor children. I may refuse to sign this authorization; however Time Insurance Company may not be able to make a payment determination without the required information. Please forward the requested information to: Assurant Health, P.O. Box 9398, Minneapolis, MN 55440. You may also fax this information to: 414-299-7555.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI, 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires when I am no longer an insured of Time Insurance Company.

Signature of Claimant or Representative*

Date

*If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS

SECTION 4: Employer's or Administrator's Statement (If self-employed, please fill out all applicable sections)

Name of Employee		Occupation	Is disability due to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Employer ____/____/____	Date Last Worked ____/____/____	Reason for Stopping Work <input type="checkbox"/> Disability <input type="checkbox"/> Dismissed <input type="checkbox"/> Resigned <input type="checkbox"/> Layoff <input type="checkbox"/> Retired <input type="checkbox"/> Family Medical Leave of Absence <input type="checkbox"/> Other Leave of Absence <input type="checkbox"/> Other Reason _____		
Date Returned to Work ____/____/____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	If returning part-time, amount of pay Employee is receiving: \$_____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week (Select one)	If Employee has not returned to work, estimated return to work date: ____/____/____	Date Employment Terminated: ____/____/____	Required number of hrs. per week: _____ hrs.
Gross Annual Salary: (During the 12 months just prior to your employee's disability) \$ _____	Please attach a copy of the following documents to this form: <input type="checkbox"/> The Employee's prior year's W-2 form <input type="checkbox"/> The Employee's current job description OR list the current job duties/description: _____			

_____ Name of Employer	_____ Print Name & Title of Official Representative
_____ Mailing Address of Employer	_____ Signature
_____ Phone No.	_____ Fax No.

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.

PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE

SECTION 5: SECTION 5: Attending Physician's Statement *(Must be filled-in completely by a Physician - Please Print or Type)*

First Name of Patient	MI	Last	<input type="checkbox"/> Male	Birth Date
			<input type="checkbox"/> Female	____/____/____
Height _____	Weight _____	Blood Pressure (last visit) Systolic _____/Diastolic _____	<input type="checkbox"/> Left-handed	
			<input type="checkbox"/> Right-handed	

1. HISTORY:

- a. Is condition due to Accident? Sickness? Pregnancy?
- b. When did symptoms first appear or injury occur? Mo. _____ Day _____ Year _____
- c. Date patient was unable to work because of impairment Mo. _____ Day _____ Year _____
- d. Has patient ever had same or similar condition? Yes No If "Yes", state when and describe

- e. Is condition due to injury or sickness arising out of patient's employment? Yes No Please explain:

- f. Was this patient referred to you? Yes No If "Yes", by whom and what is their specialty?

- g. Have you referred this patient to another treating provider? Yes No If "Yes", to whom and what is their specialty?

2. DIAGNOSIS:

- a. Diagnosis impacting function: _____
 ICD-9 Code(s) _____
 Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

- b. Secondary diagnosis impacting function: _____
 Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

- c. Subjective symptoms: _____

- d. Objective Findings (including current X-rays, EKGs, Laboratory Data and any clinical findings) _____

3. FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with:

- a. Pregnancy Yes No Date of last menstrual period: ____/____/____ Expected date of delivery: ____/____/____
- b. Delivery Yes No Actual Date of Delivery: ____/____/____ Vaginal C-Section
- c. Post Partum Yes No

If "Yes" to any of these, please specify in detail: _____
 _____**4. DATES OF TREATMENT FOR THIS CONDITION:**

- a. Date of first visit Mo. _____ Day _____ Year _____
- b. Date of last visit Mo. _____ Day _____ Year _____
- c. Next office visit Mo. _____ Day _____ Year _____
- d. Frequency Weekly Monthly Other (specify) _____

5. PROGRESS:

- a. Has patient: Recovered? Improved? Unchanged? Retrogressed?
- b. Is patient: Ambulatory? House confined? Bed confined? Hospital confined?

If "Hospital Confined", give Name and Address of Hospital _____

Confined from: ____/____/____ through: ____/____/____

6. CARDIAC (if applicable):

- Functional Capacity Class 1 (No limitation) Class 2 (Slight limitation)
- (American Heart Association standards) Class 3 (Marked limitation) Class 4 (Complete limitation)

