Short Term Disability Claim Statement

ASSURANT
Employee
Benefits

☞ **If you live in the state of Arizona, the following statement applies to you:**
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.

☞ **If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**
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.

☞ **If you live in the state of California, the following statement applies to you:**
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.

☞ **If you live in the state of Colorado, the following statement applies to you:**
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.

☞ **If you live in the District of Columbia, the following statement applies to you:**
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.

☞ **If you live in the state of Florida, the following statement applies to you:**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

☞ **If you live in the state of New Jersey, the following statement applies to you:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☞ **If you live in the state of New York, the following statement applies to you:**
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 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.

☞ **If you live in the state of Oregon, the following statement applies to you:**
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 may be guilty of insurance fraud.

☞ **If you live in a state other than mentioned above, the following statement applies to you:**
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Listed below are Assurant Employee Benefits' Regional Benefit Centers and corresponding addresses and toll-free numbers:

Assurant Employee Benefits PO Box 40918 Indianapolis Indiana 46240-0918 • T 800.283.3636
Assurant Employee Benefits PO Box 390844 Minneapolis Minnesota 55439-0844 • T 800.325.8385
Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • T 800.451.4531

DISABILITY—HIPAA Authorization for Release of Health Information

ASSURANT Employee Benefits

Insured/Member name _____ SSN _____ DOB_____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies or its representatives to determine my eligibility for disability benefits and to process my disability claim. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records, and strength/functional testing.

The sole purpose of this disclosure is for the adjudication of my disability claim.

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting Assurant Employee Benefits, Privacy Office, P.O. Box 419052, Kansas City, MO 64141-6052, but any such revocation will not affect any actions that the Companies took before receipt of the revocation.
- An authorization presented to Assurant Employee Benefits is specifically understood to be a request for information from any individually wholly-owned affiliate of Assurant, Inc.
- I may inspect and/or copy the health information described above.
- The information disclosed may be subject to redisclosure by the recipient and thereby no longer protected by HIPAA.
- I may refuse to sign this authorization; however, if I refuse to sign this authorization I may not receive disability benefits under the disability plan.
- My medical treatment or payment of medical benefits cannot be conditioned upon whether I sign this authorization.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- This authorization is effective from the date signed below until my disability claim ends or 24 months from the date signed below, whichever is earlier.

_____ _____

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE — DATE

_____ _____

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE — RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Please mail or fax your authorization to the appropriate address listed below:

Assurant Employee Benefits PO Box 40918 Indianapolis Indiana 46240-0918 • F 317.205.2201
Assurant Employee Benefits PO Box 390844 Minneapolis Minnesota 55439-0844 • F 952.920.4577
Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • F 816.556.7687

Short Term Disability Claim Statement

* Required Field

ASSURANT Employee Benefits

Part 1—To be completed by the Employer *(Please print or type. If necessary, attach separate sheet.)*

Policy no. *	Participation no.	Account no.	Full legal name of claimant *

Date employed	Effective date of insurance under this plan	Occupation, title or position

Describe the claimants job duties. **Attach a job description.**

Did this disability occur as a result of the claimant's employment? ☐ Yes ☐ No ☐ Currently disputed

Date last worked _____
No. of hours worked that day _____
Work schedule at time of disability
_____ day/week _____ hrs./day

How is claimant paid?
☐ Hourly ☐ Salary + commission
☐ Salaried ☐ Commission only
☐ Salary + bonus ☐ Other _____

Basic **weekly** earnings *(as defined in policy)*
$

Weekly benefit amount
$

Has claimant returned to work?
☐ Yes ☐ No If "Yes," on what date _____
☐ With restrictions ☐ Full capacity

Was claimant covered under your prior disability plan? ☐ Yes ☐ No
Effective date under **prior** plan _____
Termination date under **prior** plan _____

Is there any reason why FICA taxes should **not** be withheld from claimant's benefits? ☐ Yes ☐ No If "Yes," please explain.

Does the claimant contribute towards the cost of this STD insurance? ☐ Yes ☐ No
If "Yes," ☐ Pre-tax ☐ Post-tax If "Post-tax," _____% premium dollars paid by employer, _____% paid by claimant.

Has the claimant's contribution % or the pre/post-tax % changed within the past 4 calendar years? ☐ Yes ☐ No

Employer's name	Your name and title	Telephone

Do you wish to have disability checks sent directly to claimant's home? ☐ Yes ☐ No E-mail address

Date _____ By _____
AUTHORIZED SIGNATURE/TITLE

Part 2—To be completed by Claimant *(Please print or type.)*

Full name *(As it appears on your Social Security card.)*	Social Security number	Date of birth

Street address	City	State	Zip	Home phone

Sex: ☐ Male ☐ Female Type of disability: ☐ Accident ☐ Illness ☐ Pregnancy E-mail address

Describe how and where accident occurred or list symptoms of illness and diagnosis. Date first unable to work

Physician(s) name and address

Have you returned to work? ☐ Yes ☐ No If "Yes," on what date _____ Part-time _____ Full-time
If you have not returned to work, on what date do you expect to return to work _____ Part-time _____ Full-time

Check if you are receiving or are entitled to receive benefits from any of the following sources:
☐ Salary, Wages or Commissions ☐ Retirement or Pension Plan ☐ Social Security Retirement ☐ National Guard/Military Reserves
☐ State Disability ☐ Social Security Disability ☐ Railroad Retirement Act ☐ Other sources
☐ Workers' Compensation

For each source marked above, please provide us with the following information:

Source	Amount of income Amount	Frequency	Date application filed	Benefit effective date

Provide documentation of any source indicated above; i.e. award notices, denial notices, or applications.

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I understand Union Security Insurance Company may discuss my limitations/restrictions with current or prospective employers as they relate to accommodations and possible return to work. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature _____ Date _____

After completion of Parts 1 and 2, forward to Attending Physician for completion of Part 3.

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Part 3—To be completed by Attending Physician *(Please print or type. If necessary, attach separate sheet.)*

History

Patient's symptoms result from *(Check all that apply.)*:
☐ Employment ☐ Illness ☐ Auto accident ☐ Other accident ☐ Pregnancy _____ (EXPECTED/ACTUAL DELIVERY DATE) Type of delivery _____
Date symptoms first appeared _____

Please fully describe the patient's limitations. _____

When did these limitations apply? Patient's height _____ weight _____

Began _____ Anticipated reduction _____ Anticipated end date _____

Name(s) and address(es) of other treating physician(s) _____

Hospital name _____ Confinement dates _____ thru _____

Diagnoses

Diagnoses with ICD9-CM codes: list in descending order of severity *(including any complications)*. Please go to the appropriate assessment section and elaborate. ICD9 _____ _____ _____ _____

Subjective symptoms _____

Objective findings _____

Attach medical records which document the above diagnostics. *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.)*
Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No

Functional Assessment

In terms of an 8 hour day:
☐ Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently.
☐ Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently.
☐ Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently.
☐ Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting.
☐ Class 5—Severe limitation; incapable of minimal activity or sedentary* work. ☐ Bed confined ☐ House confined
*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles

Please fully describe the patient's capabilities: *With allowance for positional change.
N=Never **O**=Occasionally (1/4–2 1/2 hours) **F**=Frequently (2 1/2–5 1/2 hours) **C**=Continuously (5 1/2–8 hours)
_____ Standing* _____ Sitting* _____ Walking* _____ Driving* _____ Bending* _____ Data Entry*
Lifting not more than _____ pounds _____ *(How often?)* Carry not more than _____ pounds _____ *(How often?)*

When did these capabilities begin? _____

Do you anticipate an increase in your patient's functional capabilities? ☐ Yes ☐ No If "Yes," what date? _____

Treatment

First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____

Describe the treatment program and give dates of any surgery, medications (dosages/administrations routine), physical therapy or psychotherapy. _____

Frequency of treatment: ☐ Weekly ☐ Monthly ☐ Other *(Specify.)* _____

Psychiatric Assessment

List the patient's DSM-IV Axes: I _____ II _____

Current GAF _____ Date _____ Highest GAF in past year _____ Date _____

Please define stress as it applies to this patient.

_____

What stress and problems in interpersonal relations has patient had on the job?

_____

Please fully describe the patient's limitations.

Rehab

Is patient a candidate for vocational rehabilitation services? ☐ Yes *(Describe.)* ☐ No *(Explain.)*

Name

Physician's name _____ Degree _____ Specialty/Board certification _____

Address _____
(STREET) (CITY) (STATE) (ZIP CODE)

Telephone no. _____ Fax no. _____

Signature _____ Date _____ (DO NOT PRE-DATE) _____ (PHYSICIAN'S EIN OR SSN)