

Fax to: Claims 1-800-880-9325

From: _____

Fax Number: _____

Date: _____

Number of pages: _____

Disability Claim Form and Instructions



Your disability must be filed within 12 months of your date of loss unless you are legally unable to do so.

What can I do to avoid delays?

Missing information will delay the processing of your claim.

- **Complete** Section 1.
- **Sign and return** the Authorization. (Reverse side of page 3)
- **Sign and return** the Certification on page 3.
- Have your doctor and employer complete their sections.
- Enclose copies of all bills connected with your claim, if applicable.

When should I expect a reply?

- If you are filing a claim for a sickness or health condition occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to determine if the condition is pre-existing. We may have to write for this information which may delay your claim. **Please include the signed authorization with your claim and ask your doctor to promptly respond to our request for medical information.**

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way.

To avoid mail delays:

- **Fax** your claim to us at **1-800-880-9325**. If you fax your claim, please do not mail the original document but keep it for your records. Please allow **at least 48 hours** for our automated service center to be updated with information confirming receipt of your fax.
- Have your payment returned by **overnight delivery** by initialing the Service Release below. A \$15.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments of \$100.00 or more. Payments will not be over nighted to P.O. Box addresses.** Your check will be delivered Monday through Friday; however, the time is not guaranteed.

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.

- (Initial) I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by releasing its details with **my spouse or family member** if he/she is inquiring on my behalf.
- (Initial) I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by releasing its details with a **local sales representative** if he/she is inquiring on my behalf.
- (Initial) I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by discussing its details with my **plan administrator** if he/she is inquiring on my behalf.
- (Initial) I authorize Colonial Life & Accident Insurance Company to communicate information on the status of this claim through **electronic messaging** at my home phone number as indicated on this form.
I understand messages will be left with any person answering the phone or on my voicemail/answering machine.
- (Initial) Yes, please deduct the \$15.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from my claim payment for this claim. I understand this fee will be deducted for **future payments** for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service.
I understand payments under \$100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying Colonial in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by us.

CLAIMANT NAME: _____ **SOCIAL SECURITY NUMBER:** _____

FAX TO 1-800-880-9325

Questions? Call 1-800-325-4368 • 24 Hours A Day/7 Days a Week

OR YOU MAY MAIL TO:

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

Attn.: DISABILITY BENEFITS

P. O. BOX 100195

COLUMBIA, SOUTH CAROLINA 29202-3195



SECTION 1 TO BE COMPLETED BY POLICYOWNER

1. Policyowner name		Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	If the address given at left has changed since your last claim please mark box with an "x". <input type="checkbox"/>	
Address (Street Required for Overnight)			Policy Number		
City	State	Zip Code	Social Security Number	Birthdate (MM/DD/YYYY)	
Email Address			Home Telephone ()		Work Telephone ()
2. Claim is for: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness			3. Date and Description of Injury/Sickness		
			Were you at work at the time of your injury/sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. List dates (MM/DD/YYYY) unable to work From: To:			If not employed, list dates (MM/DD/YYYY) of house confinement*: From: To:		
5. Have you returned to your place of employment? <input type="checkbox"/> Yes, <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time			Date Returned to Work (MM/DD/YYYY)	*house confinement means unable to do normal daily activities	
6. List all doctors who have treated you for this condition and include your primary care physician's name first.					
Doctor's name		Phone Number	Address		
1.					
2.					
3.					
4.					

SECTION 2 TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

7. Dates (MM/DD/YYYY) Employee unable to work From: <input type="checkbox"/> a.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> p.m.		Date Employee returned to his/her primary duties Date MM/DD/YYYY <input type="checkbox"/> a.m. <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> p.m.			
8. Employee's Job Title					
Employee's duties include:					
Lifting	<input type="checkbox"/> less than 15 lbs.	<input type="checkbox"/> 15 to 44 lbs.	<input type="checkbox"/> over 45 lbs.		
Stooping/bending	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent		
Crawling/climbing/kneeling	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent		
Reaching/pulling/pushing	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent		
Repetitive	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent		
Management duties	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent		
Sitting (Number of hours each day): _____					
Standing/Walking (hours each day): _____					
9. If injured, did the loss occur while the employee was at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date _____.					
10. Signed by _____ Title _____					
Date (MM/DD/YYYY) _____		Employer's Telephone Number () _____			
Employer's Email Address _____		Employer's Fax Number () _____			

SECTION 3 TO BE COMPLETED BY PHYSICIAN

11. What is this patient's current primary disabling condition?

Symptoms:

Objective Findings:

12. Are there secondary conditions contributing to the disability?

Yes No

If yes, what are they and would the patient be disabled without regards to these secondary conditions?

13. List any test(s) or surgeries performed and submit a copy of the results.

14. Restrictions (What the patient SHOULD NOT do)

15. Limitations (What the patient CANNOT do)

16. How soon do you expect significant improvement in the patient's medical condition?

1-2 months 3-4 months 5-6 months more than 6 months

17. Is this patient permanently disabled? Yes No

18. Is patient considered to be house confined and/or unable to perform 2 out of 5 activities of daily living*? Yes No
**Dressing, eating, transferring, toileting and meal preparation.*

List dates (MM/DD/YYYY) of house confinement.* From: _____ To: _____

**House confinement means unable to do normal daily activities.*

19. Dates of Total Disability (MM/DD/YYYY) From: _____ To: _____

Dates of Partial Disability (MM/DD/YYYY) From: _____ To: _____

Patient's expected return to work date (MM/DD/YYYY) _____

20. List All Office Visit Dates:

List All Hospitalization Dates:

21. Is patient currently being treated by any other practitioner or therapist? If so, list name and address.

Name and Address of Hospital

22. Signature of Physician or Supplier Date (MM/DD/YYYY)

Physician's supplier and group name

Telephone Number

Tax ID or SSN

Address

()

23. Fax Number

Patient Number

()

PLEASE SIGN AND RETURN THE AUTHORIZATION (ON REVERSE SIDE) AND CERTIFICATION BELOW TO AVOID DELAY.

CERTIFICATION

Policyholder/Employee's Name _____ Social Security Number _____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form.

_____/_____/_____
Date(MM/DD/YYYY)

PATIENT SIGNATURE

POLICYHOLDER/EMPLOYEE SIGNATURE

Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial will not disclose the information unless permitted or required by those laws. This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of individual subject to this disclosure)

(Social Security Number)

(Signature)

(Date Signed)

If applicable, I signed on behalf of the insured as _____(indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of legal representative)

(Signature of legal representative)

(Date Signed)