Disability Claim Filing Instructions

Have you…

1. Completed the Employee's Statement in full?
2. Had the physician treating you complete the Attending Physician's Statement, and had it returned to you?
3. Had your Employer complete the Employer's Statement, and had it returned to you?
4. Read, signed and dated the Authorization for Release of Information?

Submit the completed statements to the address below or fax to 1-(866) 376-9480

All portions of these forms must be completed in order to expedite your claim.

If you have any questions when completing this form, please call:

Toll-Free Phone Number 1-(866) 376-9478

Disability RMS
One Riverfront Plaza
Westbrook, Maine 04092-9700

Disability RMS
Fax 1-(866) 376-9480
Toll Free Phone 1-(866) 376-9478

NOTICE OF CLAIM FOR ☐SHORT-TERM DISABILITY BENEFITS
☐LONG-TERM DISABILITY BENEFITS

EMPLOYEE'S STATEMENT **(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)**

NAME OF EMPLOYEE

EMPLOYEE'S SOCIAL SECURITY - -

EMPLOYEE'S ADDRESS — STREET & NO. — CITY — STATE — ZIP

TELEPHONE NO. ( ) -

DATE OF BIRTH / /

☐ MALE ☐ FEMALE

☐ RIGHT-HANDED ☐ LEFT-HANDED

MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

IS SPOUSE EMPLOYED? ☐ YES ☐ NO

NUMBER OF DEPENDENT CHILDREN

LIST NAMES AND DATES OF BIRTH OF SPOUSE AND DEPENDENT CHILDREN

HOW MANY HOURS WERE YOU REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER? ______ hrs.

GROSS ANNUAL SALARY: (During the 12 months just prior to your disability - for this employer only) $ __________________

PLEASE INDICATE HOW YOU ARE PAID: ☐ 9 MOS./YR. ☐ 10 MOS./YR. ☐ 12 MOS./YR. ☐ OTHER ________________________

NAME OF EMPLOYER

EMPLOYER'S TELEPHONE NO. ( ) -

EMPLOYER'S ADDRESS — STREET & NO. — CITY — STATE — ZIP

YOUR OCCUPATION & TITLE

LIST ESSENTIAL DUTIES OF YOUR JOB AT THE TIME OF DISABILITY

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? ☐ YES ☐ NO

IF "YES", EXPLAIN:

DID YOU FILE FOR WORKERS' COMPENSATION? ☐ YES ☐ NO

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.

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? ☐YES ☐NO
IF "YES", WHEN?
____

TREATED BY:
HOSPITAL: ____
Name — Street Address — City — State — Zip

DOCTOR: ____
Name — Street Address — City — State — Zip

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FOR PREGNANCY DISABILITY ONLY:
Are there any present complications or anticipated difficulties in connection with the following?

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: ____

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay	$ ________	________	________	☐	☐
☐	☐	Salary Continuance	$ ________	________	________	☐	☐
☐	☐	Workers' Compensation	$ ________	________	________	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ ________	________	________	☐	☐
☐	☐	No Fault	$ ________	________	________	☐	☐
☐	☐	Unemployment Compensation disability	$ ________	________	________	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ ________	________	________	☐	☐
☐	☐	Retirement income (normal, early, or disability)	$ ________	________	________	☐	☐
☐	☐	Other STD/LTD Benefits	$ ________	________	________	☐	☐
☐	☐	Other (describe) ________	$ ________	________	________	☐	☐

HAVE YOU APPLIED, OR DO YOU PLAN TO APPLY FOR BENEFITS DESCRIBED ABOVE? ☐ YES ☐ NO

TYPE ____________________________________ DATE APPLICATION FILED ______________
TYPE ____________________________________ DATE APPLICATION FILED ______________

<u>California Residents:</u> 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."

Signature of Employee ____ Date ____________

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA COMPLIANT - to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency including the Social Security Administration, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability RMS Administrators (Disability RMS), and Union Security Insurance Company and including, but not limited to, any other mental or psychiatric condition or treatment records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse) (*but excluding psychotherapy notes and Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results)* which may have been acquired in the course of examination or treatment. I understand that the information obtained using this authorization will be used by Disability RMS, Union Security Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Disability RMS or Union Security Insurance Company to assist with the evaluation and adjudication of my current disability claim and/or to report aggregate claims information to Union Security Insurance Company. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may not be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or Union Security Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

Claimant Signature (or Authorized Representative)____________________ Date: _______

Description of Personal Representative's Authority (if applicable):
(If signed by authorized representative, attach verification of identity)

Disability RMS
Fax 1-(866) 376-9480
Toll Free Phone 1-(866) 376-9478

NOTICE OF CLAIM FOR ☐SHORT-TERM DISABILITY BENEFITS
☐LONG-TERM DISABILITY BENEFITS

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT **(ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)**

NAME OF EMPLOYEE	OCCUPATION	IS DISABILITY DUE TO EMPLOYMENT? ☐ YES ☐ NO

DATE EMPLOYED	DATE INSURED	DATE LAST WORKED	REASON FOR STOPPING WORK
/ /	/ /	/ /	☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason ____

DATE RETURNED TO WORK	IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK	IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE:	DATE EMPLOYMENT TERMINATED	DATE DISABILITY INSURANCE TERMINATED
/ / ☐ FULL-TIME ☐ PART-TIME		/ /	/ /	/ /

REQUIRED NUMBER OF HRS. PER WEEK	GROSS ANNUAL SALARY: (During the 12 months just prior to your employee's disability)	PLEASE INDICATE HOW THE EMPLOYEE IS PAID:
_________ hrs.	$ ____________	☐ 9 MOS./YR. ☐ 10 MOS./YR. ☐ 12 MOS./YR. ☐ OTHER ________

IS EMPLOYEE SUBJECT TO FICA TAX? ☐ YES ☐ NO
IF "YES", IS EMPLOYEE SUBJECT TO ☐ FULL FICA TAX ? ☐ MEDICARE PORTION ONLY?

PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN
(AS OF POLICY YEAR OF DISABILITY)
EMPLOYEE ☐ 100% ☐ OTHER ___________% IS EMPLOYEE CONTRIBUTION: ☐ PRE-TAX DEDUCTION?
EMPLOYER ☐ 100% ☐ OTHER ___________% ☐ AFTER-TAX DEDUCTION?

EMPLOYEE ELIGIBLE FOR:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay	$ ______	______	______	☐	☐
☐	☐	Salary Continuance Benefits	$ ______	______	______	☐	☐
☐	☐	Workers' Compensation	$ ______	______	______	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ ______	______	______	☐	☐
☐	☐	No-fault	$ ______	______	______	☐	☐
☐	☐	Unemployment Compensation disability	$ ______	______	______	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ ______	______	______	☐	☐
☐	☐	Retirement income (normal, early, or disability	$ ______	______	______	☐	☐
☐	☐	Other LTD/STD Benefits	$ ______	______	______	☐	☐
☐	☐	Other (describe) ______	$ ______	______	______	☐	☐

PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTS TO THIS FORM:

- The employee's Workers' Compensation claim(s) and Approval/Denial Notification
- The employee's prior year's W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability
- The employee's current job description

<u>California Residents</u>: 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".
I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

___________________________ ___________________________
NAME OF POLICYHOLDER (COMPANY) *PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE*

___________________________ ___________________________
MAILING ADDRESS OF POLICYHOLDER (COMPANY) *SIGNATURE* *DATE*

(________)________ - ________________ (________)________ - ________________
TELEPHONE NUMBER *FAX NUMBER*

PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE

Disability RMS
Fax 1-(866) 376-9480
Toll Free Phone 1-(866) 376-9478

ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN

(Please Print or Type)

Name of Patient ______________________________ *FIRST* *MIDDLE* *LAST*		☐ Male ☐ Female	Date of Birth / /
Height ___________ Weight ___________	Blood Pressure (last visit) Systolic __________/ Diastolic __________	☐ Left-handed ☐ Right-handed	

1. HISTORY:

a. Is condition due to ☐ Accident? ☐ Sickness?
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: ______________________________ ICD9 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 ____________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

6. CARDIAC (if applicable)

Functional Capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
(American Heart Assoc. standards) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

7. CURRENT FUNCTIONAL ABILITY

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

___ Hrs. Sedentary Activity 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.

___ Hrs. Light Activity 20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.

___ Hrs. Medium Activity 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.

___ Hrs. Heavy Activity 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

b. Please check appropriate box:

	Occasionally 0% to 33%		Frequently 33% to 66%		Continuously 66% to 100%	
Bending	☐		☐		☐	
Climbing	☐		☐		☐	
Reaching	☐		☐		☐	
Kneeling	☐		☐		☐	
Squatting	☐		☐		☐	
Crawling	☐		☐		☐	
Push/pull	☐	No. of lbs._______	☐	No. of lbs._______	☐	No. of lbs._______
Lifting (lbs.)	☐	No. of lbs._______	☐	No. of lbs._______	☐	No. of lbs._______

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific. ____

____

____

____

d. Upper Extremity Function - Please indicate upper extremity functional capabilities:

Simple grasp	☐ Left	☐ Right	Comments ________________
Pinch	☐ Left	☐ Right	Comments ________________
Fine manipulation	☐ Left	☐ Right	Comments ________________
Power grip	☐ Left	☐ Right	Comments ________________
Repetitive motion	☐ Left	☐ Right	Comments ________________

8. MENTAL HEALTH ABILITY (if applicable)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

____

____

9. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b. The date you released patient to return to work: ______/_______/______ ☐ Full-time ☐ Reduced hours Number of hours: __________
MO. DAY YEAR

c. Please identify your recommendations for any job modifications that would enable the patient to work.

____

____

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ATTENDING PHYSICIAN'S SIGNATURE ____________________________ DATE ________________

PHYSICIAN'S NAME (PLEASE PRINT) ____

DEGREE/SPECIALTY ____

TELEPHONE NUMBER (______)________-_________ FAX NUMBER (_______)_______- __________ TAX ID # ____________________

OFFICE ADDRESS ____
NUMBER/STREET

____
CITY OR TOWN STATE ZIP CODE

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE