Short Term Disability Claim Form

UniCare Life & Health Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 1-800-813-5682 Fax: 1-800-850-0017
Email: disability@anthem.com

Important notice to employee — Please read carefully: You or someone acting on your behalf should complete Section 1 and then have your employer complete Section 2. Have your physician complete Section 3. Also complete and sign the *Authorization for Release of Information, Communication Consent,* and *Reimbursement Agreement* forms. Submit the forms to us at the address or fax number listed to the right. Your cooperation will facilitate payments promptly when they are due.

Any person who knowingly, and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

Notice to customers regarding telephone service observance — To ensure our customers receive quality service, all of our phone calls are recorded. These calls, between our customers and employees, are evaluated by supervisors. This is to assure that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

Section 1: To be completed by the employee

Last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)

Social Security no.	Employee street address	City	State	ZIP code

Primary phone no.	Alternate phone no.	Fax no.	Email address

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Employer name

Disability due to ☐ Illness ☐ Injury	Date you last worked due to your disability	Date you returned to work	If not yet returned, date you expect to return

If disability due to injury, what type? ☐ Auto ☐ Workers' Compensation ☐ Home ☐ Other: _____

Please provide complete details to accident, date and time. Attach a separate sheet if necessary.

_____

For New York residents, the following statement applies: 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 $5,000 and the stated value of the claim for each violation.

I authorize the release to or by UniCare Life & Health Insurance Company (UniCare) any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing UniCare to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. Your signature is required for benefit consideration.

Employee signature **X**	Date (MM/DD/YYYY)

Section 2: To be completed by the employer

Group policy no.	Date employed (MM/DD/YYYY)	Effective date of insurance	Occupation/job title

Employee Social Security no.	Employee no. (if applicable)	Employee benefit class ☐ Part-time ☐ Fill-time	Standard no. of hours worked per week

Date employee last worked	No. of hours	Date employee scheduled to return to work	Date employee returned to work

Amount of weekly benefits	Employee's wage $ _____ per ☐ Hour ☐ Week ☐ Month ☐ Year	Employee's compensation ☐ Hourly ☐ Salaried

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No

Is claim being made for Workers' Compensation? ☐ Yes ☐ No

What percentage of the Short Term Disability premium does the employer pay? _____%

If the employee contributes to the premium, contributions are made: ☐ Pre-tax ☐ Post-tax

Is the employee receiving any compensation (sick pay, vacation, salary continuation)? ☐ Yes ☐ No Attach additional sheets if needed.
If so, please provide dates and amounts: _____

Group name	Branch or division address	Phone no.

Signature of employer representative **X**	Printed name of employer representative	Title	Date (MM/DD/YYYY)

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Section 3: To be completed by the physician

Note to physician: Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

Patient last name	First name	M.I.	Birthdate (MM/DD/YYYY)

Patient street address	City	State	ZIP code

Current diagnosis: _____

ICD10/DSM5: _____

Subjective complaints: _____

Objective findings: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, specify dates of treatment: _____

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

Is disability due to pregnancy? ☐ Yes ☐ No EDC: _____ Type of delivery: ☐ Vaginal ☐ C-section

Was patient hospitalized? ☐ Yes ☐ No If yes, please provide date of confinement: _____
Name of hospital/facility: _____

Nature of surgical procedure, if any. Date performed: _____
Describe in full: _____

Date patient first unable to work	Date of first visit	Date of last visit	Date of next visit

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

Treatment plan: _____

Functional impairments: _____

Current medications and dosages: _____

Patient released to return to work? ☐ Yes ☐ No
If yes: ☐ Full-time, no restrictions Date able to return to full duty: _____
☐ Light duty Date able to return to light duty: _____
Please specify restrictions, limitations, hours, graduated return to work schedule, etc.:
_____

Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

Printed physician name	Physician tax ID no.	Physician specialty

Physician street address	City	State	ZIP code

Physician phone no.	Physician fax no.	Physician email address

Physician signature **X**	Date (MM/DD/YYYY)

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Disability
Employee Authorization for Release of Information
(HIPAA compliant)

UniCare®

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, 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, to give any and all such information to authorized representatives of UniCare Life & Health Insurance Company (UniCare) and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by UniCare 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 UniCare solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

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 UniCare in writing, of my revocation. However, such revocation is not effective to the extent that UniCare 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 UniCare's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING UNICARE to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and UNICARE shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant printed name	Birthdate (MM/DD/YYYY)
Claimant signature **X**	Date (MM/DD/YYYY)

Relationship of authorized person	Description of personal representative's authority, if applicable (If signed by authorized representative, attach verification of identity.)

Send completed form to:

UniCare Life & Health Insurance Company
Disability Claim Service Center
P.O. Box 105426
Atlanta, GA 30348-5426

For customer service:

Call: 1-800-813-5682
Fax: 1-800-850-0017

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The laws of some states require us to provide you with the following information

UniCare®

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: A person who knowingly and with intent to injure, defraud, or deceive 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.

Arkansas, Louisiana, Rhode Island, and West Virginia: 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.

California: For your protection California law requires the following statement 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 and Idaho: 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.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

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, 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 may include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps to 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 N.H. Rev. Stat. Ann. §638:20.

New Jersey: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: A 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 $5,000 and the stated value of the claim for each violation.

Ohio: 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 is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Texas: 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.

General Fraud Warning: Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal penalties.

Communication Consent

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The Telephone Consumer Protection Act of 1991 (TCPA), the Federal Communications Commission's (FCC) regulations and interpretative orders implementing the TCPA, the Federal Trade Commission's (FTC) Telemarketing Sales Rule of 2003 (TSR), and parallel state laws (collectively referred to as the Telecommunications Laws) impose strict rules governing how UniCare Life & Health Insurance Company (UniCare) may place outbound telephone calls and send text messages for Sales and Non-sales purposes to individuals.

In order to comply with the new federal regulation, please provide below what numbers we can contact you on in regard to your claim.

Phone number you wish to be contacted on: _____

This phone is: ☐ Cell phone
☐ Land line

Is this phone number registered on the National Do Not Call Registry? ☐ Yes ☐ No

Does UniCare have permission to contact you on this number? ☐ Yes ☐ No

Print your name: _____

Your signature: X_____

Date signed: |__|__|__|__|__|__|__|__| (MM/DD/YYYY)

Reset Form Save and Print

Reimbursement Agreement

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Employee last name: _____ First: _____ M.I. ____

Social Security no: |_|_|_|_|_|_|_|_|_|

First date absent: |_|_|_|_|_|_|_|_| (MM/DD/YYYY)

Employer: _____ Group no.: _____

I acknowledge that I am eligible for benefits under the disability plan sponsored by the above named employer whose claims for plan benefits are either insured by or administered on an employer self-funded basis by UniCare Life & Health Insurance Company (hereinafter referred to as UniCare). I agree to reimburse UniCare 100% of the amount of benefits I receive, have received, or shall receive from any person or entity for loss wages incurred as a result of the occurrence which gave rise to my claim for payment of benefits from the disability plan. In the event that the 100% reimbursement provided in the preceding sentence is greater than the amount of my recovery, less attorney fees and other legal expenses I incurred in obtaining such recovery (my net recovery), I agree to reimburse UniCare the entire amount of my net recovery.

I agree to keep UniCare fully informed as to the status of my payment recovery so that UniCare may take whatever action it deems necessary to protect its interest. I also agree to authorize any person including, but not limited to, any insurance company, attorney, hospital, physician, surgeon or pharmacist to release to UniCare any information pertaining to this occurrence, or claim.

I also acknowledge that UniCare will have the right to recover any overpayment of benefits, either directly from me or by deduction of the amount of the overpayment from my future benefits payable under the disability plan, which are the result of error caused by or misinformation provided to UniCare.

Your signature: **X** _____

Date signed: |_|_|_|_|_|_|_|_| (MM/DD/YYYY)

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