Colonial Life

Disability Claim

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia, SC 29202	From:	
		Number of pages:	

Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual inquiring on my behalf.
Note: Leave blank if you do not want anyone accessing your claim information.

_____ Spouse, family member or significant other Name: _____

_____ I want Colonial Life to update me on the status of my claim through electronic messaging at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your phone.

_____ **Yes, I want ALL payment(s) for this claim sent by overnight delivery.** I understand payment(s) under $100.00 cannot be sent overnight. I also understand that if I want my claim to be sent by overnight delivery, a **$22.00 fee** will be deducted from my claim payment. This fee is subject to rate increases by carrier and does not include weekend delivery. **I understand that Colonial Life is unable to send overnight mail to a P.O. Box. I also understand that I must notify Colonial Life to discontinue this service.**

Complete each section before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim.

- If your name has changed, attach a copy of your driver's license or other legal documentation.
- Dates should be written in month/day/year format (i.e. 12/14/1980).
- Social Security number is indicated by SSN.
- Benefits are payable to you unless we receive written authorization to pay benefits elsewhere. This is called an assignment.
- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

Section 1 – Claimant statement (completed by policy owner)

Claimant name:	☐ Male ☐ Female	DOB: ____ /____ /_____	SSN:
Relationship to policy owner: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent			
Policy owner information (if other than claimant) — Name:		DOB: ____ /____ /_____	SSN:
Address:	City:	State:	ZIP:
Email:		Contact number:	
Claim is for: ☐ Accident ☐ Sickness	Date the accident occurred (not when it was treated): _____ /_____ /_____		
Condition that keeps you from working:			
Have you been treated for same or similar condition prior to this occurrence? ☐ Yes ☐ No If yes, date: _____ /_____ /_____			
Description of how the accident occurred (if auto accident, attach a copy of the accident report):			

Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others, require the following statement to appear on this claim form. **Fraud Warning:** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

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.

California, Rhode Island, Texas and West Virginia: For your protection, California, Rhode Island, Texas and West Virginia law requires the following to appear on this form: Any person who knowingly presents 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.

District of Columbia: 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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: For your protection, Kentucky law requires the following to appear on this form: 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 a 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.

New Jersey and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil 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 five thousand dollars and the stated value of the claim for each such violation.

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

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present; it may be reduced to a minimum of two (2) years.

Claimant name:	**Claimant SSN:**

Section 1 – Claimant statement ~ continued (completed by policy owner)

Were you at work at the time of your accident or sickness? ☐ **Yes** ☐ **No**	**Have you filed for Worker's Compensation benefits or Occupational Accident Benefits** ☐ **Yes** ☐ **No**
Have you been unable to work: ☐ **Yes** ☐ **No** **If yes, list the dates unable to work:** From: _____ / _____ / _____ To: _____ / _____ / _____	
If not working, have you been unable to perform activities of daily living? ☐ **Yes** ☐ **No** **If yes, list dates:** From: _____ / _____ / _____ To: _____ / _____ / _____	
Hourly rate:	**Hours worked per week:**
Check activities of daily living that you are unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Toileting ☐ Continence ☐ Bathing ☐ Transferring	
If not actively at work, list dates of house confinement: From: _____ / _____ / _____ To: _____ / _____ / _____ House confinement means that you are kept at home (in house or yard) by the condition. However, you may follow the physician's orders, even if it means leaving home.	
Date returned to work: Full-time: _____ / _____ / _____ Part-time: _____ / _____ / _____ If part-time, hours worked per week: _____	

Please submit itemized billing if confined to a hospital, as well as an operative report, if surgery was performed.

Hospital confinement: ☐ **Yes** ☐ **No**

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Hospital:	Telephone:		
Address:	City:	State:	ZIP:

List all physicians who have treated you for this condition.

Primary physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:

Certification

Policy owner's name: _____ SSN: _____

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. I acknowledge that I received the Claim Fraud Statements on page two of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. **Fraud Warning:** 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.

_____	_____	_____
Print claimant's name	Claimant's signature	Date (MM/DD/YYYY)
_____	_____	_____
Print policy owner's name	Policy owner's signature	Date (MM/DD/YYYY)

Claimant name:	**Claimant SSN:**

Section 2 – Physician statement (completed by physician)

Patient name:	DOB: _____ / _____ / _____
Is condition due to an accidental injury? ☐ Yes ☐ No	If yes, date and description of accidental injury:
What primary diagnosis prevents the patient from working? (If pregnancy, list complications. If routine pregnancy, complete information below.)	Date first treated for this condition: _____/ _____/ _____
Are there any secondary diagnoses preventing the patient from working? ☐ **Yes** ☐ **No**	Secondary diagnoses:
When did symptoms first appear? _____ / _____ / _____	Date of new patient consultation: _____ / _____ / _____ / Symptoms:
Current treatment plan:	
List all dates patient received: medical advice, diagnosis or treatment for this condition (or a related condition) for the 18 months prior to this disability to the present.	(list dates: MM/DD/YYYY)
List any test performed (submit copy of test results) Date: _____/ _____/ _____ CPT code: _____ Date: _____/ _____/ _____ CPT code: _____	List any surgeries performed (submit copy of operative report) Date: _____/ _____/ _____ CPT code: _____ Date: _____/ _____/ _____ CPT code: _____
Date of patient's last visit: _____ / _____ / _____ / Date of next scheduled visit: _____ / _____ / _____	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
Does patient have permanent restrictions and/or limitations? ☐ **Yes** ☐ **No** If yes, which ones are permanent:	Limitations (patient CANNOT DO): / Restrictions (patient SHOULD NOT DO):
Dates unable to work (full-time): From: _____ / _____ / _____ To: _____ / _____ / _____	**Expected return to work:** _____ / _____ / _____
Dates able to work (part-time): From: _____ / _____ / _____ To: _____ / _____ / _____ Number of hours: _____	**Actual return to work:** _____ / _____ / _____
Did this condition require house confinement: ☐ Yes ☐ No If yes, From: _____ / _____ / _____ To: _____ / _____ / _____ House confinement means the patient is kept at home (in house or yard) by the condition. However, the patient may follow your orders, even if it means leaving home.	
Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence	
Dates unable to perform activities of daily living: From: _____/ _____/ _____ To: _____/ _____/ _____	
Date(s) of hospitalization (last 6 months):	Date(s) of office visit (last 6 months):

How often do you see the patient?			Have you referred patient to a specialist? ☐ **Yes** ☐ **No**		
Hospital:			Specialist:		
Address:			Address:		
City:	State:	ZIP:	City:	State:	ZIP:
Telephone:	Fax:		Telephone:	Fax:	

PREGNANCY	Estimated date of delivery: _____ / _____ / _____	Type of delivery: ☐ Vaginal ☐ C-section
Date first treated: _____ / _____ / _____	Date of delivery: _____ / _____ / _____	Procedure code:

Fraud warning: **Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes attending physician portions of the claim form.**

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

Physician/group name:			Patient account number:	
Physician's specialty:	Telephone:	FAX:		
Address:	City:	State:	ZIP:	
Tax ID or SSN:	Do you accept medical record requests by fax? ☐ Yes ☐ No			
Do you require a special authorization for release of information? ☐ **Yes** ☐ **No**	Will you accept the standard HIPAA release? ☐ **Yes** ☐ **No**			
Was patient referred to you by another physician? ☐ **Yes** ☐ **No**	Authorization on file to release information to Colonial Life: ☐ **Yes** ☐ **No**			
Referring physician:	Telephone:	Fax:		
Address:	City:	State:	ZIP:	

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 Life) 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 work history or any other facts deemed necessary by Colonial Life 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 Motor Carrier, Motor Carrier representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance. Some information once 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 Life will not re-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. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life 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 Life may not be able to evaluate my claim or eligibility for insurance. 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.

I may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer my claim or eligibility for insurance.

I am the individual to whom this authorization applies or that person's legal guardian, power of attorney designee, conservator, beneficiary or personal representative.

_____ _____

Signature | Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure | Last four digits of SSN | Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed (MM/DD/YYYY)