Short Term Disability Claim Statement

ASSURANT
Employee
Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:
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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:
A 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, Maryland, or Rhode Island 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:
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 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING: 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. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia 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 New Hampshire, the following statement applies to you:
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 RSA 638:20.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms “we,” “us,” “our,” and the like, refer to each as applicable.

Following is the information for claim submission:

Assurant Employee Benefits PO Box 972030 El Paso Texas 79997-2030
• T 800.451.4531 • F 816.556.7687 • KCBenefitCenter@assurant.com

If you live in 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 Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

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 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.

After completion of the authorization on this page, and Parts 1 and 2, forward to Attending Physician for completion of Part 3.

To be completed by Claimant:

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, 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 treating physicians and 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.

Signature of claimant _____ Date _____

HIPAA Authorization For Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. 5469783 Participation no. n/a Account no. n/a Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance company, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, 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 benefits and to process my 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 claim for insurance benefits under the above-referenced Policy.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

_____ _____

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 address below:

Assurant Employee Benefits PO Box 972030 El Paso Texas 79997-2030
• 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 *
5469783	n/a	n/a	

Date employed	Effective date of insurance under this plan	Occupation, title or position **Attach a job description.**

Did this disability occur as a result of the claimant's employment?

☐Yes ☐No ☐Currently disputed

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

$

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 _____

Effective date of last salary change

Weekly benefit amount

$

What is the claimant's current employment status?

If terminated, what date _____; and is claimant eligible for rehire? ☐Yes ☐No If holding job, how long _____

Note type of income the claimant is currently receiving:

	Amount	Frequency	Beginning Date	End Date
Vacation pay				
Sick pay or Salary continuance				
Paid time off-in lieu of vacation				
Paid time off-in lieu of sick pay				
Paid time off-no distinction				

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

Additional comments regarding this claim :

Employer's name	Your name and title
Southern Medical Corporation	Kelli Deloach / HR Director

By _____ Date _____ Telephone 225-756-5239

E-mail address kellid@southernmedical.com Fax No: 225-756-4556

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

Short Term Disability Claim Statement

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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

Complete address	City	State	Zip	Phone #

E-mail address

Sex : ☐Male ☐Female

Type of disability: ☐Accident ☐Illness ☐Pregnancy

Marital Status: ☐Single ☐Married

☐Widow ☐Divorced Youngest child's date of birth _____

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:

☐Workers' Compensation ☐Retirement or Pension Plan ☐Social Security Retirement ☐National Guard/Military Reserves

☐State Disability ☐Social Security Disability ☐Railroad Retirement Act ☐Other sources

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

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

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

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 Name _____ Date of birth _____

Patient's symptoms result from *(Check all that apply.)*:

☐Employment ☐Illness ☐Auto accident ☐Other accident ☐Pregnancy _____ Type of delivery _____
EXPECTED/ACTUAL DELIVERY DATE

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