CUSTOM DISABILITY SOLUTIONS

GROUP DISABILITY CLAIM APPLICATION

☐ **Short Term Disability (STD)**
SEND TO:
CUSTOM DISABILITY SOLUTIONS
P.O. BOX 9461
PORTLAND, ME 04104-5056
TEL: (888) 234-2641
FAX: (800) 293-4781

☐ **Long Term Disability (LTD)**
SEND TO:
CUSTOM DISABILITY SOLUTIONS
P.O. BOX 9461
PORTLAND, ME 04104-5056
TEL: (877) 448-1999
FAX: (207) 883-8641

To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization (to be completed by you, the employee)
Section 2: Employee's Statement
Section 3: Employer's Statement
Section 4: Physician's Statement

When ALL sections of this form have been completed, please fax or mail it to us. Use the fax number or address above that corresponds to the type of disability for which you are applying.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Section 1: To Be Completed By Employee

TO:

- Physicians and Other Health Care Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
- Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration ("SSA"), Internal Revenue Service, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers, including worker's compensation insurers or administrators, and Pre-Paid Health Plans
- Pharmacies and Pharmacy Benefit Managers
- State Vocational Rehabilitation Agencies and other providers of rehabilitation services
- Medical Information Bureau (MIB) or other companies, which collect health and insurance information
- Attorney Representatives, or advocates for SSA benefits

You are authorized to provide information related to my health condition and job modifications/accommodations with my current or future employer to:

- Custom Disability Solutions (CDS);
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

This form allows the release of the following information, collectively referred to as "Information":

- Records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations and prescriptions;
- Employment-related information, including any claims for workers' compensation;
- Income and tax-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering benefits for short term disability, long term disability, salary continuation, workers' compensation, which are excepted benefits under HIPAA, or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), developing a vocational rehabilitation plan, and other purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program under which I may be a participant, employers, reinsurers, the SSA, claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain in force for a period of 24 months or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address above. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of CDS to process my claim and may lead to the denying or terminating of my claim for benefits.

Claimant's Signature: _____ Date: _____

Claimant's Full Name: _____ Date of Birth: _____

If the insured is unable to sign, an authorized representative may sign below for the insured

Representative Signature: _____ Date: _____

Description of Representative's Authority to Sign:_____

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CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several jurisdictions, including Arizona, California, Colorado, Connecticut, District of Columbia, Florida, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico and others, require the following statements:

For residents in all jurisdictions except Arizona, California, Colorado, Connecticut, District of Columbia, Florida, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, and Puerto Rico - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For Arizona residents - 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.

For California residents - Any person who knowingly presents a false or fraudulent claim for the payment of a loss 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.

For Colorado residents - It is unlawful to knowingly provide false, incomplete, or misleading material 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 material 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.

For Connecticut residents - Any person who knowingly presents false or fraudulent claim, as determined by a court of competent jurisdiction, 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.

For District of Columbia residents - 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.

For Florida residents - 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.

For Maryland residents - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

For New Hampshire residents - Any person who, with a purpose to injure, defraud, or deceive an 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 under New Hampshire Insurance Statute RSA 638:20.

For New Jersey residents - Any person who includes any false or misleading information in an application for an insurance policy is subject to criminal and civil penalties.

For New York residents - 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.

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For Pennsylvania residents - 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 and subjects such person to criminal and civil penalties.

For Puerto Rico residents - 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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, and if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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Employee's Statement

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1	Employee Name			**2** Social Security No.
	Street/Box/Apt.			**3** Phone No. ( )
	City, State, Zip			**4** Date of Birth
5	Height	**6** Weight	**7** ☐ Male ☐ Female	**8** Employer Name
9	Occupation	**10** List Occupation Duties		
11	Date of accident or date of first symptoms	**12** Last Day Worked	**13** Are you unable to work due to: (check one) ☐ Injury ☐ Illness ☐ Pregnancy	
14	Date you Returned to Work		☐ Full Time ☐ Part Time	
15	If you have not returned to work, when do you expect to return?		☐ Full Time ☐ Part Time	

16 Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms

17 Is your accident or illness related to your occupation? ☐ Yes ☐ No
If yes, explain:

18 Have you filed a Workers' Compensation Claim? ☐ Yes ☐ No If no, do you intend to? ☐ Yes ☐ No
If no, explain:

19 When were you first treated for your illness or accident?

Hospital	Address	Date(s)
Doctor	Address	Date(s)

20 Have you ever had same or similar condition in the past? ☐ Yes ☐ No If yes, list name and address of Hospital/Doctor below

Hospital	Address	Date(s)
Doctor	Address	Date(s)

21 Are you receiving any of the following? (Check each benefit you are receiving)

	Amount	Begin date	End date		Amount	Begin date	End date
☐ Workers' Compensation	$_____	_____	_____	☐ Unemployment	$_____	_____	_____
☐ Social Security	$_____	_____	_____	☐ Other (Indiv. or Group)*	$_____	_____	_____
☐ State Disability	$_____	_____	_____	☐ Auto Ins. Wage Replacement*	$_____	_____	_____
☐ Canadian Pension Plan	$_____	_____	_____				

*If yes, give name and address of Insurer below

Insurer Name(s)	Address

22 ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**23** If married, spouse's name and Social Security No.	**24** Spouse Date of Birth	
25 Is Spouse Employed? ☐ Yes ☐ No	**26** List Children under age 25 (Names and Dates of Birth)		

27 If benefits are approved, do you want the minimum $20.00 per week withheld from your check for Federal Income Tax purposes? ☐ Yes ☐ No
If you want more withheld, please state dollar amount you want withheld $ _____

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

Signature **X** _____ Date _____

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Employer's Statement

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1	Employee's Name			**2** Social Security No.
	Street/Box/Apt.			**3** Date of Birth
	City, State, Zip			**4** Regularly Scheduled Hours Per Week
5	Date of Hire	**6** Employee's STD Effective Date	**7** Employee's LTD Effective Date	**8** Occupation
9	Policy No.	**10** Policy Division No.		**11** Policy Class

12 Employee's Work Schedule ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal

13 Check Regular Workdays ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

14 If not at work when disability began, check status and provide date

☐ Terminated ☐ Leave of Absence ☐ Other:
☐ Laid Off ☐ Sick Leave
☐ Vacation ☐ Resigned

Date _____

15 How was employee paid? (check frequency and types)

Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly

Type(s): ☐ Hourly ☐ Bonus ☐ Salary ☐ Commission

16 Salary Prior to Date Last Worked Base Weekly Wages $ _____ W-2 Earnings $ _____ Overtime $ _____ Commissions $ _____ Bonus $ _____	**17** Date Last Salary Increase **18** Employee Work Schedule at Time Last Worked _____ Days per week _____ Hours per week	**19** New York DBL? ☐ Yes New Jersey TDB? ☐ Yes (If yes, complete reverse side)	

20 Date Last Worked	**21** Hours Worked That Day	**22** Has Employee Returned to Work? ☐ Yes ☐ No If yes, Date _____	☐ Full Time ☐ Part Time

23 Date Paid Through _____ For ☐ Salary Continuation ☐ Vacation ☐ Accrued Sick Pay

24 Does employee contribute toward the STD premium? ☐ Yes ☐ No If yes, ☐ Pre-Tax ☐ Post-Tax

If Post Tax, _____% paid by employer _____% paid by employee

25 Does employee contribute toward the LTD premium? ☐ Yes ☐ No If yes, ☐ Pre-Tax ☐ Post-Tax

If Post Tax, _____% paid by employer _____% paid by employee

26 Employee is Eligible for:	Yes	No	If yes, Weekly or Monthly Amount	Wk	Mo	Provider Name/Address	Date Benefits Begin	Through
Salary Continuation	☐	☐	$	☐	☐			
Disability Pension	☐	☐	$	☐	☐			
Retirement Pension	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Unemployment	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Workers' Compensation	☐	☐	$	☐	☐			
Has Workers' Comp. claim been filed?	☐	☐	If Workers' Compensation has been denied, submit copy of denial with this claim.					

27 Does your company have a rehire or return to work policy for disabled employees? ☐ Yes ☐ No

What is the name of the person we should contact if we identify a return to work option?

28 Name/Address of the employee's medical insurance carrier or HMO (provide policy or ID No.)

29	Employer's Name		Phone No. ( )	
	Street Address	City	State	Zip
	Signature (The above statements are true and complete to the best of my knowledge) **X**		Date	

A Job Description is required if employee is out of work more than 6 weeks.

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Employer's Statement

Section 3: To Be Completed By Employer

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.

Complete this side if the employee is eligible to receive New York (DBL), or New Jersey (TDB).

Employee Name	Social Security No.	Weekly Wages Last Day Worked
		$

In the following spaces show dates and claimant's GROSS earnings in New York and/or New Jersey employment during the last weeks prior to the week disability began.

	Calendar Week End Date	Gross Wages
Calendar Week in Which Disability Began	_____	$ _____
Prior Week Before Disability	_____	$ _____
2nd Week Before Disability	_____	$ _____
3rd Week Before Disability	_____	$ _____
4th Week Before Disability	_____	$ _____
5th Week Before Disability	_____	$ _____
6th Week Before Disability	_____	$ _____
7th Week Before Disability	_____	$ _____
8th Week Before Disability	_____	$ _____
	Total	$ _____

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Physician's Statement

Section 4: To Be Completed By Physician

Patient Name	Date of Birth	Social Security No.

Height	Weight	Blood Pressure (last visit)

1 Patient is/was unable to work due to: (check one) ☐ Injury ☐ Illness ☐ Pregnancy

2 Diagnosis (include complications and ICD 9)

For Normal Pregnancy, complete items 3-6, then skip to item 25

3 What was LMP date?	**4** What is the expected date of delivery?	**5** Date First Treated	**6** Date Last Treated

For all conditions except Normal Pregnancy, complete the following items

7 When did symptoms first appear or accident happen?	**8** Date you advised patient to stop working	**9** Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No

10 Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe

11 Date of First Visit	**12** Date Last Visit	**13** Frequency of Visits

14 Objective Findings (X-rays, EKG's, lab data and clinical findings)	**15** Subjective Symptoms

16 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency

17 Names and addresses of other physicians

18 Has patient been hospitalized? ☐ Yes ☐ No If Yes, give name and address

From _____ to _____

19 Restrictions (what the patient **SHOULD NOT** do)	**20** Limitations (what the patient **CANNOT** do)

21 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis

I

II

III

IV

V

22 If this is a cardiac condition, what is the functional capacity? (American Heart Association)
☐ Class 1 - No Limitation ☐ Class 2 - Slight Limitation ☐ Class 3 - Marked Limitation ☐ Class 4 - Complete Limitation

23 Has maximum medical improvement been achieved? ☐ Yes ☐ No
If no, when do you expect a fundamental change? ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ More than 6 weeks

24 If employer can accommodate patient's limitations and restrictions, is patient able to return to work? ☐ Yes ☐ No
If yes, what date could employment begin?

25 Physician Name (Please Print) | Degree

Specialty	Phone No.	Fax No.

Address	City	State	Zip

Signature (No Stamp)	Tax ID No.	Date
X		