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:	

File Your Claim Online

Simply log into your account at Coloniallife.com and click on "File an Online Claim".
As an added convenience, you may also select Direct Deposit when filing online.
Not a member? Log onto Coloniallife.com and click on "Register" then "Join the Policyholder Website" to set up your account.

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.

_____ Sales representative _____ Employer _____ Spouse, family member or significant other Name: _____

_____ I want Colonial Life to update me on the status of my claim through prerecorded messages 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, includes delivery only on business days and does not include weekend or holiday delivery. **I understand that Colonial Life is unable to send overnight mail to a P.O. Box.**

_____ **Yes, I want to Direct Deposit all payments into my bank account.** I have enclosed a voided check for a checking account or a deposit slip for a savings account with my initial claim submission. Please note: Allow up to three business days after claim payment for deposit into your account.

I also understand that I must notify Colonial Life to discontinue any of these services.

Complete each section before submitting your claim. If you were not employed when the disability began, the employer's statement in section 2 is not needed. Incomplete claim form submission may result in a delay in the processing of your claim. Please make sure that all written responses are legible.

- If your name has changed, attach a copy of legal documentation of the change.
- 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: Apt. #		City:	State:	ZIP:
Email:			Telephone/Contact Number:	
Claim is for: ☐ Accident ☐ Sickness	Date the accident occurred (not when it was treated): _____/_____/_____			
Condition that keeps you from working:			Is your condition work related?	
Have you been treated for same or similar condition prior to this occurrence? ☐ Yes ☐ No If yes, date: _____/_____/_____				
Description of where and how the accident occurred (if auto accident, please attach a copy of the police report, if available.)				

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming 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.

California: 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: 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.

Minnesota: A person who files a claim with intent to defraud or helps 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 RSA 638.20.

New Jersey: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution 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**	**Is your condition work related?** ☐ **Yes** ☐ **No**

Have you filed for workers' compensation benefits? ☐ **Yes** ☐ **No** (If on-job injury, attach copy of Report of Injury document)

Have you been unable to work: ☐ **Yes** ☐ **No** **If yes, list the dates unable to work:** From: _____ / _____ / _____ To: _____ / _____ / _____

What is your job title/occupation?	What specific job duties are you unable to perform?

Were you employed at time of loss? ☐ **Yes** ☐ **No**	If not employed at the time of loss, what was the last date that you worked at the previous occupation?

If not employed at the time of loss, what was the last date that you worked at the previous occupation?

If not employed, have you been unable to perform activities of daily living? ☐ **Yes** ☐ **No** **If yes, list dates:** From: _____ / _____ / _____ To: _____ / _____ / _____

Check activities of daily living that you are unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Toileting ☐ Continence ☐ Bathing ☐ Transferring

If not employed, 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:

Claimant name:	**Claimant SSN:**

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: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the 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.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalities. This includes the Physician Statement portion of the claim form.

_____	_____	_____
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 – Employer statement (completed by employer)

Employee name:			SSN:
Employee title:			Hire date: _____ / _____ / _____
Average number of scheduled hours per week:	Date last worked: _____ / _____ / _____	Date employment terminated: _____ / _____ / _____	
Employee unable to work (Full-time): From: _____/ _____/ _____ To: _____/ _____/ _____		Sick leave was exhausted on: _____ / _____ / _____	
Approved for FMLA (if eligible): From: _____/ _____/ _____ To: _____/ _____/ _____		Was employee at work when accident or sickness occurred? ☐ **Yes** ☐ **No**	
Workers' compensation claim filed? ☐ **Yes** ☐ **No**	Workers' compensation carrier Name:	Telephone:	
Hourly employee rate:	Hours worked per week:	Annual salary:	If paid on commission basis, attach commission breakdown for prior 12 months from date last worked.
Do you permit light duty for employee? ☐ **Yes** ☐ **No**		Do you permit partial duty for employee? ☐ **Yes** ☐ **No**	
Expected return to work: _____ / _____ / _____	Actual return to work: Full-time: _____ / _____ / _____	Actual return to work: Part-time: _____ / _____ / _____ Hours per week:_____	
Employee's duties include:	☐ **Sitting** _____ per hr. ☐ **Walking** _____ per hr. ☐ **Climbing stairs/ladders** _____ per hr. ☐ **Standing** _____ per hr. ☐ **Driving** _____ hrs. per day		
	Lifting: ☐ Less than 15 lbs. ☐ 15 to 44 lbs. ☐ More than 45 lbs. **Stooping/bending:** ☐ none ☐ seldom ☐ frequent		
Reaching/pulling/pushing: ☐ none ☐ seldom ☐ frequent **Crawling/kneeling:** ☐ none ☐ seldom ☐ frequent **Repetitive motion:** ☐ none ☐ seldom ☐ frequent			
Contact for updates on return to work status:		Telephone:	
Email:		Fax:	

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 employer's portions of the claim form.

_____ Signature of authorized person	_____ Date (MM/DD/YYYY)
Title of authorized person:	Employer/company name:

Telephone:	Fax:	Email:

Claimant name:	**Claimant SSN:**

Section 3 – 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)	List any surgeries performed (submit copy of operative report)
Date: _____/ _____/ _____ CPT code: _____	Date: _____/ _____/ _____ CPT code: _____
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**	Patient Portal ☐ **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:
Tax ID or SSN:	

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Authorization for Colonial Life & Accident Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

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 and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

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, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. 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 or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), 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 I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

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)