UnitedHealthcare

Claim Forms and Instructions for Group Short Term Disability

EMPLOYER

EMPLOYER – *Form Completion Information*:

NOTICE OF CLAIM – Instructions

1. **COMPLETE**
   - Employer's Report of Claim *(Page 2)*
2. **INCLUDE:**
   - Job Description (detailed duties)
   - Copy of enrollment card (if employee contributes to premium)
   - Copy of approved medical evidence of insurability if required at time of enrollment
   - Documentation of earnings
   - If Workers' Compensation claim filed, include copy of First Report of Accident and the decision
   - Life Insurance Enrollment Form if: Self Billed and covered under a UnitedHealthcare Specialty Benefits group LTD and Life Insurance Policy.
3. **TRANSMIT** completed forms and attachments to:

   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 888 299 2070 Fax 888 505 8550
4. **PROVIDE** employee with the accompanying Claim Forms *(Pages 3 – 8)*
   - Group Short Term Disability Claim Instructions
   - Employee's Short Term Disability Statement
   - Employee's Disclosure Authorization
   - Employee's Authorization of Personal Representative
   - Attending Physician's Statement. If there is more than one treating physician, an additional claim form should be provided for each.
5. **REQUEST:**
   - Copy of awards from other source of benefits: Social Security, Workers' Compensation, Retirement, State Disability, others

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING EMPLOYEE'S REQUEST FOR BENEFITS

1. Employee's Name:	2. Social Security Number:	3. Date of Birth:

4. Address:	City:	State:	Zip Code:

5. Location/Division:	6. Insurance Class:	7. Employee Date of Hire:	8. Effective Date of Coverage:

9. Employee Contribution to premium: ☐ Yes* ☐ No *If EE paid please provide enrollment card	10. If Yes: ☐ Pre-tax ☐ Post-tax	11. If Post-tax*: _____ % paid by employer _____ % paid by employee *If this section is blank, we will assume it is 100% employer contributions and calculate FICA taxes accordingly. Please refer to IRS Publication 15A.

12. Employee's Occupation at time last worked:	13. Job Duties:

14. Employee's Work Status: ☐ Full-Time ☐ Non-Exempt ☐ Union ☐ Part-Time ☐ Exempt	15. Regular scheduled hours per week:	16. Check off Regular work days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

17. Date employee was actually last present at work:	18. Reason for stopping work: ☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Retired ☐ Dismissed ☐ Other : ☐ Resigned ☐ Vacation	19. Termination Date (if applicable):

20. Has employee returned to work? ☐ Yes ☐ No	21. If Yes: ☐ Part-time Date: _____ ☐ Full-time Date: _____	22. How is employee paid? ☐ Straight Salary ☐ Hourly $ _____ ☐ Salary & Commissions* ☐ Salary & Bonus ☐ Commission Only * ☐ Other: _____ *If paid commission, attach breakdown for 12 mos. prior to last day worked

23. Salary prior to date last worked (refer to earnings definition in your contract) $ _____ OR Flat Benefit Amount $ _____	24. Salary Period (check one): ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

25. Is Employee Eligible for:	Yes	No	If YES, weekly or monthly amount	Check One: Weekly	Check One: Monthly	Provider or Carrier Name & Address	Benefit Date: Begin Date	Benefit Date: Through Date
Salary Continuation	☐	☐	$	☐	☐			
Other Disability Benefits	☐	☐	$	☐	☐			
Disability Pension	☐	☐	$	☐	☐			
Retirement Pension	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Auto No Fault	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Other Benefits	☐	☐	$	☐	☐			
Workers' Compensation	☐	☐	$	☐	☐			

26. Did Claim result from job activity? ☐ Yes (Explain below) ☐ No	27. Has a Worker's Compensation claim been filed? ☐ No ☐ Yes (Enc. copy of 1st Report of accident) ☐ Pending ☐ Denied (Enc. copy)

28. Is the company holding the employee's position? ☐ Yes ☐ No	29. Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No	30. If Yes, please describe:

31. What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

_____ _____ _____
Name Title Telephone Number (include area code)

32. Is this employee also covered under a UnitedHealthcare LTD and Life Insurance Policy? ☐ Yes* ☐ No *If yes, please provide:

Life Group No: _____ Basic Benefit Amount $_____ Supplemental Benefit Amount: $_____
If Self Billed, please provide a copy of the Life Enrollment Form

Employer's Name (name of policyholder, if other)	Telephone Number (include area code)	Policy No
Address	Employer (Taxpayer) I.D. No. (EIN)	Public Employer SS No. 69
Name of person completing this form (please type or print)	Title	
Signature of person completing this form	Date	

UnitedHealthcare®

Claim Forms and Instructions for Group Short Term Disability

EMPLOYEE

EMPLOYEE – *Form Completion Information*:

APPLICATION for Group Short Term Disability - Instructions

1. **COMPLETE** Employee's Short Term Disability Statement *(Pages 4 & 5)* in FULL.

   ATTACH copies of Social Security, Worker's Compensation, Retirement and other income entitlement awards and/or denials (or forward when received).

2. **COMPLETE** Employee's Disclosure Authorization *(Page 6)*. This will allow us to secure additional information, if necessary, to make a decision on your claim for benefits. Make a copy to provide to your treating physician(s).

3. **COMPLETE** Employee's Authorization of Personal Representative *(Page 7).* If you would like us to discuss your claim with anyone, we require your authorization prior to us releasing any personally identifiable health information. *This form is optional and not required to file a claim.*

4. **TRANSMIT** completed forms and attachments to:

   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 888 299 2070 Fax 888 505 8550

5. **PROVIDE** the Attending Physician's Statement *(Page 8)* to the physician(s) treating you. If you have more than one physician, obtain additional Attending Physician's Statements from your employer.

6. **PROVIDE** a copy of your completed Employee's Disclosure Authorization to your physician(s).

7. **INSTRUCT** your physician(s) to send completed form(s) to:

   UNITEDHEALTHCARE SPECIALTY BENEFITS
   PO Box 7466
   Portland, ME 04112-7466
   Tel 888 299 2070 Fax 888 505 8550

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING YOUR REQUEST FOR BENEFITS

1. Employer's Name (include division if applicable):				
2. Insured's Full Name (Last, First, Middle Initial):		3. Social Security Number:		4. Phone Number (include area code):
5. Address:		City:	State:	Zip Code:
6. Date of Birth:	7. Height:	8. Weight:	9. Gender: ☐ M ☐ F	10. Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced
11. Spouse First and Last Name:		12. Spouse Date of Birth:		13. Is spouse employed? ☐ Yes ☐ No
14. Your Occupation (List the duties of your occupation at the time of disability):		15. What parts of your job are you unable to do?		
16. Is your claim a result of an accident? ☐ Yes ☐ No	17. If YES, please provide the date and type of your accident:	Date:	Type:	
18. Describe in detail, the nature of and the onset of your illness or injury:				
19. Date you first noticed symptoms of illness/injury:	20. Date last worked:	21. I returned to work on: ☐ Part-time ☐ Full-time	22. I expect to return to work on: ☐ Part-time ☐ Full-time	
23. Is your accident or illness related to your occupation? ☐ Yes ☐ No	24. If Yes, please explain:	25. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No	26. If No, do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No	
27. If your injury or illness is due to an auto accident, have you applied for no-fault benefits? ☐ Yes ☐ No	28. If Yes, provide the Name, Address & Phone Number of the carrier:			
29. When were you first treated for your injury or illness?		30. Have you ever had the same or a similar condition in the past? ☐ Yes, When? _____ ☐ No		

31. Provide the names, addresses and date you first saw the doctor(s) who are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.

Physician Name	Phone No. Fax No:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No
Physician Name	Phone No. Fax No:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No
Physician Name	Phone No. Fax No:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No
Physician Name	Phone No. Fax No:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ☐ Yes ☐ No

(Continued on next page)

32. Are you receiving or have you applied for any of the following benefit? (Include benefits for you or any family member)

Type of Benefit	Receiving Payments (Yes/No)	Amount Received	Applied for or appealed No decision	Claim denied no appeal pending
Social Security Disability				
SS Retirement				
Family/Dependent Social Security Disability				
State Retirement				
Long Term Disability*				
VA Disability				
Workers' Compensation				
Pension Benefits				

*Name, Address, & phone number of insurance company along with claim number of long term disability claim:

33. Are you receiving, have you received or have you applied for any type of payment from any employer's retirement member plan? ☐ Yes* ☐ No * If YES, complete:

Name, Address and Telephone Number of Employer:

Effective Date:

Amount of Award: $

☐ Weekly ☐ Monthly ☐ Annual

If Lump Sum, Amount: $

Date Received:

If applied for only, give details:

Provide copies of any decisions, including denial and/or award notices for any benefits noted above

34. If your request for benefits is approved, do you want the minimum $20.00 per week withheld from your check for Federal Income Tax purposes? ☐ Yes ☐ No

35. If you would like more than $20.00 withheld, please state the whole dollar amount you want withheld weekly. Amount $ _____(Minimum amount per week is 20.00)

The above statements are true and complete to the best of my knowledge and belief.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Date: _____/_____/_____ **Signature:** _____

Address: _____ **Phone (_____) _____ - _____**

Participant's Name (Please Print):_____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give Unimerica Life Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

Relationship, if other than Claimant: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

At my request, and for my convenience, I, _____ hereby authorize **Unimerica Life Insurance Company** and any representatives thereof involved in the administration of my disability claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **Unimerica Life Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **Unimerica Life Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/_____

Signature: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

ATTENDING PHYSICIAN'S DISABILITY STATEMENT **TO BE COMPLETED (for employee) BY PHYSICIAN**

Legible completion of this form is requested to ensure prompt service to your patient.

1. Patient Name/Medical Record Number (please print, maiden name if applicable)		2. Date of Birth Height Weight	
3. When did symptoms first appear or accident happen?	4. Date you advised patient to stop working?	5. Has patient ever had the same or similar condition? ☐ Yes ☐ No	If yes, state when and describe
6. Is condition due to or exacerbated by injury/ sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown	7. Name & address of other treating physicians		
8. Date of first visit for this illness	9. Date of last visit	10. Diagnosis & ICD10 code (include complications)	
11. Subjective symptoms		12. Objective findings (including current x-rays, EKG's lab and/or clinical findings)	
13. Nature of treatment			
14. If pregnancy, expected delivery date	15. If delivered, actual delivery date	16. ☐ Vaginal delivery ☐ C - Section	
17. Was patient hospitalized? ☐ Yes ☐ No	Name & address of hospital	Date Admitted	Date Discharged

18. Physical Capacity (Reference: Dictionary of Occupational Titles)

- ☐ Very heavy – frequent standing/walking, lift/carry over 100 lbs.
- ☐ Heavy - frequent standing/walking, lift/carry up to 100 lbs.
- ☐ Medium - frequent standing/walking, lift/carry up to 50 lbs.
- ☐ Light - frequent standing/walking, lift/carry up to 20 lbs.
- ☐ Sedentary – sitting most of the time, lift/carry up to 10 lbs.
- ☐ No work capacity – ADLs (Activities of Daily Living) only.

19. Mental Capacity (Reference: DSM-IV-TR)

- ☐ GAF 61-70 – Some mild symptoms (some difficulty in social, occupational); generally functioning well.
- ☐ GAF 51-60 – Moderate symptoms (moderate difficulty in social, occupational); flat affect, occasional panic attacks, conflict with peers.
- ☐ GAF 41-50 Serious symptoms (serious impairment in social, occupational); no friends, suicidal, unable to keep job.
- ☐ GAF 31-40 Some impairment in reality testing, speech at times illogical, major impairment in several areas.
- ☐ GAF < 30 Behavior influenced by delusions and/or hallucinations; acts grossly inappropriate.

20. Please define "stress" as it applies to this patient	21. What stress and problems in interpersonal relations has patient had on the job?	
22. Additional Remarks		
23. Please describe any *limitations your patient has in his/her activities (*limitations – activities that cannot be performed).		
24. Please list any *restrictions you have placed on your patient's activities (*restrictions – activities that should not be done to prevent progression of disease).		
25. **Expected Return to Work Date**	26. Can patient resume full duties upon return to work? ☐Yes ☐ No	If no, please explain?

27. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐Yes ☐ No

Physician's Name	Degree & Specialty	Tax ID Number
Address	Telephone Number:	
	Fax Number:	
Physician's Signature	Date:	

Return To: UNITEDHEALTHCARE SPECIALTY BENEFITS PO Box 7466 Portland ME 04112-7466 Tel 888-299-2070 Fax 888-505-8550

For claimants in 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.

For claimants in 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.

For claimants in 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.

For claimants in California:

Unimerica Life Insurance Company may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for Unimerica Life Insurance Company's approval of your coverage under the policy.

For claimants in 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.

For claimants in Connecticut:

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Delaware:

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.

For claimants in 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.

For claimants in 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

For claimants in Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in Idaho:

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For claimants in Indiana:

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

For claimants in Kansas:

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 may be guilty of fraud as determined by a court of law.

For claimants in 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.

For claimants in Maine:

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.

For claimants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

For claimants in Minnesota:

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

For claimants in 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.

For claimants in New Jersey:

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

For claimants in New Mexico:

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 civil fines and penalties.

For claimants in 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.

For claimants in Oklahoma:

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

For claimants in Oregon:

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in Tennessee 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 include imprisonment, fines and denial of insurance benefits.

For claimants in 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.

For claimants in Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:

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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:

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.