



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, New Mexico, 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 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.

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, Hawaii, Maine, Tennessee, Virginia or Washington, 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.

Listed below are our Regional Benefit Centers and corresponding addresses, toll-free numbers and fax numbers:

Assurant Employee Benefits PO Box 40918 Indianapolis Indiana 46240-0918 • T 800.283.3636 • F 317.205.2201

Assurant Employee Benefits PO Box 390844 Minneapolis Minnesota 55439-0844 • T 800.325.8385 • F 952.920.4577

Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • T 800.451.4531 • F 816.556.7687

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 Ohio, the following statement applies to you:

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.

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 person files an application for insurance or statement of claimant 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.

HIPAA Authorization For Release of Protected Health Information



Insured/Member name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ 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 appropriate address listed below:

Short Term Disability Claim Statement



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
Date employed	Effective date of insurance under this plan		Occupation, title or position
Describe the claimants job duties. Attach a job description.			Did this disability occur as a result of the claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed
Date last worked _____	How is claimant paid?		Basic weekly earnings (as defined in policy)
No. of hours worked that day _____	<input type="checkbox"/> Hourly	<input type="checkbox"/> Salary + commission	\$ _____
Work schedule at time of disability	<input type="checkbox"/> Salaried	<input type="checkbox"/> Commission only	Weekly benefit amount
_____ day/week _____ hrs./day	<input type="checkbox"/> Salary + bonus	<input type="checkbox"/> Other _____	\$ _____
Has claimant returned to work?		Was claimant covered under your prior disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date _____		Effective date under prior plan _____	
<input type="checkbox"/> With restrictions <input type="checkbox"/> Full capacity		Termination date under prior plan _____	
Is there any reason why FICA taxes should not be withheld from claimant's benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain.			
Does the claimant contribute towards the cost of this STD insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," <input type="checkbox"/> Pre-tax <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer's name	Your name and title		Telephone
Do you wish to have disability checks sent directly to claimant's home? <input type="checkbox"/> Yes <input type="checkbox"/> No			E-mail address
Date _____ By _____		AUTHORIZED SIGNATURE/TITLE	

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	
Street address		City	State	Zip
				Home phone
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Type of disability: <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy		E-mail address	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:				
<input type="checkbox"/> Salary, Wages or Commissions <input type="checkbox"/> Retirement or Pension Plan <input type="checkbox"/> Social Security Retirement <input type="checkbox"/> National Guard/Military Reserves				
<input type="checkbox"/> State Disability <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Railroad Retirement Act <input type="checkbox"/> Other sources				
<input type="checkbox"/> Workers' Compensation				
For each source marked above, please provide us with the following information:				
Source	Amount of income	Frequency	Date application filed	Benefit effective date

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

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.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____ Date _____

After completion of Parts 1 and 2, forward to Attending Physician for completion of Part 3.

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's symptoms result from (Check all that apply): <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident <input type="checkbox"/> Pregnancy _____ Type of delivery _____ Date symptoms first appeared _____ EXPECTED/ACTUAL DELIVERY DATE
Diagnoses	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Functional Assessment	In terms of an 8 hour day: <input type="checkbox"/> Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently. <input type="checkbox"/> Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently. <input type="checkbox"/> Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently. <input type="checkbox"/> Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting. <input type="checkbox"/> Class 5—Severe limitation; incapable of minimal activity or sedentary* work. <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <small>*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles</small> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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? <input type="checkbox"/> Yes (Describe.) <input type="checkbox"/> 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