USAble Life℠

EDUCATOR'S LONG TERM DISABILITY INSURANCE CLAIM FORM

SUBMIT YOUR CLAIM
Complete all fields and return to USAble Life
Attention: Claims Department
Mail: P.O. Box 9757 | Portland | ME | 04104-9757
Email: claims@yourbenefitexpert.com
Fax: (207) 766-3448

CUSTOMER CARE
(877) 254-0085 Monday-Friday, 8 a.m. to 5 p.m. EST

TYPE OF CLAIM (required section)

☐ **ACCIDENT** ☐ **SICKNESS** ☐ **MATERNITY**

CLAIM SUBMISSION CHECKLIST (review and ensure you have all that is required for your claim to be processed)

ALL CLAIMS
1. Claim Form (all required sections)
2. Fraud Notice
3. Authorization Statement
4. Physician's Statement (admit and discharge summary, emergency room report, and office visit notes)

SECTION 1: EMPLOYEE'S STATEMENT (required section)

Employee Name (last, first, middle)	Gender ☐ Male ☐ Female
Address (street, city, state, and ZIP)	Date of Birth
	SSN
	Email Address
Occupation (be specific)	Home Telephone No.
	Mobile Telephone No.
What are your symptoms, and how are they preventing you from working?	
Is your disability work related?	
On what date (month/day/year) did you first miss work due to your disability?	
When did you first receive treatment for your disability? Provide the date (month/day/year):	
What was the name of the physician or clinician where you received your first treatment?	
Physician or Clinician Address (street, city, state, and ZIP)	Telephone No.
If your disability is due to an accident, please provide the name and address for any responsible third party.	

List all physicians and clinicians who have provided treatment or consultation for this disability (use a separate sheet of paper if necessary)

Physician or Clinician Name and Address (street, city, state, and ZIP)	Telephone No.	Date (month/day/year)
Physician or Clinician Name and Address (street, city, state, and ZIP)	Telephone No.	Date (month/day/year)

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SECTION 1: EMPLOYEE'S STATEMENT CONTINUED (required section)

Have you had a similar condition or required medical attention in the past 5 years? ☐ Yes ☐ No (if yes, summarize and provide details)

List all physicians whom you have consulted or received treatment from for any condition in the past 5 years (use a separate sheet of paper if necessary)

Physician Name and Address (street, city, state, and ZIP)	Telephone No.	Date (month/day/year)
Physician Name and Address (street, city, state, and ZIP)	Telephone No.	Date (month/day/year)

What is your return-to-work date (month/day/year)?

If you do not have a return-to-work date, what is the estimated return to work date (month/day/year)?

Identify all other income sources and monthly amounts you are receiving, or may be entitled to receive, during this disability. Include a copy of the award or denial letter for all income sources. If any benefits have been denied, include information on the status of a request for reconsideration or appeal.

☐ Social Security (disability or retirement for yourself)	$	☐ V.A. Benefits	$
☐ Social Security (dependent)	$	☐ Workers' Compensation	$
☐ Retirement (normal, early, or as a result of a disability)	$	☐ Disability Insurance	$
☐ Unemployment	$	☐ Other (provide)	$

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USAble Life, its re-insurers, and legal representatives for the purpose of evaluating this claim form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities; driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This authorization does not authorize the release of genetic screening or testing results. I also authorize USAble Life or its re-insurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. This authorization shall remain valid for a period of two years.

FRAUD WARNING: FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE: 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.

I attest to the fact that the information provided is, to the best of my knowledge, complete and accurate.

Signature	Date

THIRD PARTY SHARING: I authorize USAble to use and disclose my information (including my name, Social Security number, and disability claim information) to (i) third party administrators involved in claims processing (ii) other service providers, including health and wellness benefit plans or programs. I understand that if I do not wish to participate in the information disclosure under item (ii), I may request to opt out by calling 1- 800-370-5856, upon which I will be asked to verify my identity.

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SECTION 2: EMPLOYER'S STATEMENT (required section — employer must complete)			
Employee Name (last, first, middle)			
Address (street, city, state, and ZIP)			
Date of Birth	Telephone No.	Email Address	
Employer Name			
Contact Name and Title			
Address (street, city, state, and ZIP)		Email Address	
Group Policy No.	Telephone No.	Fax No.	
Employee's Hire Date		Coverage Effective Date	
Date Employee Last Worked		Employee's Hours Worked (per week)	
Employee's Base Salary		Employee is paid ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	
Date Employee Returned to Work		Employee's Scheduled Days to Work (check all that apply) ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.	
Status Employee Returned to Work ☐ Full time ☐ Part time			
If the employee is on a rotation schedule, how many days per week are worked or scheduled to work?			
Employee's Occupation at Time of Leave (attach a job description for all non-maternity claims)			
Has a Workers' Compensation claim been filed, or is a claim expected to be filed for this employee's disability? ☐ Yes ☐ No If yes, what is the status of the claim? ☐ Pending ☐ Approved ☐ Denied ☐ Denied on Appeal			
Workers' Compensation Carrier Name and Address (street, city, state, and ZIP)		Telephone No.	Email Address
Do you offer employees a pension or retirement? ☐ Yes ☐ No (if yes, provide contribution percentages)			
Employee contribution percentage		Employer contribution percentage	
Can the employee return with accommodations, or do you require a 100% release to work?			
I attest to the fact that the information provided is, to the best of my knowledge, complete and accurate.			
Signature of Contact		Date	

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SECTION 3: ATTENDING PHYSICIAN'S STATEMENT (physician must complete)	
Name of Patient (last, first, middle)	
Date of Birth	SSN
Date of Disability	Date of First Visit
Diagnosis and Concurrent Conditions (must have ICD-10 to process)	
Has patient ever had same or similar condition? ☐ Yes ☐ No (if yes, provide date (month/day/year)	
Was the patient hospitalized? ☐ Yes ☐ No (if yes, answer below)	
If the patient was hospitalized, the patient was treated as ☐ Inpatient ☐ Outpatient	
Admission Date (month/day/year)	Discharge Date (month/day/year)
Hospital Name and Address (street, city, state, and ZIP)	Telephone No.
Is the disability due to an accident or sickness arising out of or in the course of the patient's employment? ☐ Yes ☐ No	
Is the disability due to an accident? ☐ Yes ☐ No (provide date and explain)	
Were there surgical procedures performed as a result of the disability? ☐ Yes ☐ No (if yes, provide date and explain)	
Is the disability due to a pregnancy? ☐ Yes ☐ No (if yes, choose delivery date and type of delivery)	
Delivery date was: ☐ Actual ☐ Estimate date of LMP	Type of delivery was: ☐ Vaginal ☐ C-Section
How long was/will the patient be unable to work due to the disability? Provide from and to dates (month/day/year):	
Provide date (month/day/year) the patient will be able to return to work:	
List all treatment dates during the month in which the disability began:	
What are the patient's restrictions and limitations?	
Are there any circumstances causing the disability to be prolonged?	
Physician's Name (last, first, middle)	
Physician's Degree	Fax No.
Physician's Address (street, city, state, and ZIP)	Telephone No.
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Signature of Physician	Date

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SECTION 4: AUTHORIZATION FOR RELEASE OF INFORMATION (required section)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state, or local government agency including the Social Security Administration, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me, and any nonmedical information about me, (including any information, data, or records regarding my Social Security, FICA earnings history, Workers' Compensation, State Disability, pension, credit, earnings, and employment history) to give any and all such information to authorized representatives of USAble Life excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital, and pharmacy records (including psychiatric, alcohol, and drug abuse, and human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) information) that may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by USAble Life and the above-described representatives to evaluate and adjudicate my current disability claim. The information may be re-disclosed to: (a) any medical, investigative, financial or vocational specialist or entity, or any other organization or person employed by or representing USAble Life, to assist with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand USAble Life and the above-described representatives may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations, and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules or any other federal or state law.

This authorization is valid for two years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying USAble Life in writing of my revocation. However, such revocation is not effective to the extent USAble Life has relied previously upon this authorization for the use or disclosure of my protected health information. I understand USAble Life cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair USAble Life's ability to evaluate my current disability claim and as a result the lack of required information may be a basis for denying that current disability claim for benefits.

IF YOU RESIDE IN CALIFORNIA: This authorization excludes the release of HIV/AIDS information and test results. Separate authorizations signed by the insured claimant or employee-claimant (for self-insured business) are required each time results are released.

IF YOU RESIDE IN CONNECTICUT, MAINE, OR MASSACHUSETTS: This authorization excludes the release of information about HIV/AIDS. A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

IF YOU RESIDE IN VERMONT: This authorization excludes the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-cell counts, AIDS, or ARC. The proposed insured is not authorizing USAble Life to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and USAble Life shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Name (last, first, middle)	Date of Birth
Signature	Date

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FRAUD NOTICE

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FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE: 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. Please see below for special notices required by state law for residents.

AL	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.
AK	Any 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.
AZ	**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.
CA	For your protection, California law requires the following to appear on this form. 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.
CO	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.
DE	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.
DC	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.
FL	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.
ID	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.
IN	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.
KS	Fraudulent insurance act defined; amount involved defined; penalty; notification of commissioner, when; antifraud plan. (a) For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.
KY	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.
ME	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.

RETURN THE ORIGINAL TO USABLE LIFE AND RETAIN A COPY FOR YOUR RECORDS.

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MD	Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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.
MN	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NH	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.
NJ	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NM	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 criminal penalties.
OH	Any person who, with the 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.
OK	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
OR	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 subject to fines and confinement in prison.
PA	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.
RI	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.
TN	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.
TX	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.
VA	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.
VT	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
WA	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.

SIGN AND DATE BELOW (I have read and understand the Fraud Notice that applies to my state of residence.)

Name (last, first, middle)	Telephone No.
Signature	Date

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