USAble Life℠

SHORT TERM DISABILITY CLAIM | PROCESS

FOR QUESTIONS, CONTACT CUSTOMER SERVICE AT 877-254-0085, MONDAY THROUGH FRIDAY, 8 a.m. - 5 p.m. EST.

WHERE TO SUBMIT YOUR CLAIM:
Attention: Claims Department
Mail: P.O. Box 9757 | Portland | ME | 04104-9757
Email: claims@yourbenefitexpert.com | **Fax:** 207-766-3448

STEP 1 KNOW YOUR PLAN

Pick up a copy of your certificate of coverage from your employer's benefits department to locate your benefit plan's maximum benefit duration, elimination period, and any pre-existing conditions limitations the policy may contain.

STEP 2 OBTAIN THE REQUIRED DOCUMENTS

To process your disability claim, please submit the following documents:

You complete:
- ☐ **EMPLOYEE STATEMENT**
- ☐ **AUTHORIZATION TO RELEASE**
- ☐ **FRAUD NOTICE**

Your employer completes:
- ☐ **EMPLOYER STATEMENT**

Your physician completes:
- ☐ **ATTENDING PHYSICIAN STATEMENT**

STEP 3 SUBMIT YOUR CLAIM FORM & DOCUMENTS

To submit your claim via email, scan and email your documents to claims@yourbenefitexpert.com. You can also send your claim via fax to 207-766-3448, or by mail to ATTN: Claims Department, P.O. Box 9757, Portland, ME 04104-9757.

CLAIM EXAMINATION PROCESS

Once we've received all the necessary documents and information to process your claim, your case will be assigned to one of our dedicated claims examiners. In 95% of all cases, a decision to pay, pend, or deny a claim is reached within five business days of receipt of all necessary information.

YOUR CLAIM WILL BE IN ONE OF THE FOLLOWING PHASES:

- **INCOMPLETE:** Occurs when one or more of the required parts of the claim form are missing or not completed.
- **PENDING:** Occurs when the claims examiner is waiting on information outside of USAble Life.
- **APPROVED:** Claim is typically approved through the next scheduled office visit with your physician.
- **DENIED:** If claim cannot be certified or approved, it will be denied. A letter will be sent explaining the denial and our appeal process.

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SHORT TERM DISABILITY CLAIM FORM

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EMPLOYEE STATEMENT - TO BE COMPLETED BY THE EMPLOYEE

1. Employee Name (First, MI, Last)	2. Date of Birth	3. Social Security Number	4. Gender ☐ Male ☐ Female

5. Street Address (Address, City, State, Zip)	6. Home Phone Number	7. Cell Phone Number
	8. Do you authorize us to leave detailed messages on your primary phone number? ☐ Yes ☐ No	

9. Mailing Address (If different than Street Address)	10. Email Address
	11. Preferred method of communication: ☐ Home Phone Number ☐ Cell Phone Number ☐ Email

12. Employer Name	13. Employer Contact
14. Employer Address (Address, City, State, Zip)	15. Employer Phone Number

16. Occupation	17. Last Day Actively at Work	18. First Full Day of Disability	19. Expected Return Date	☐ Full-time ☐ Part-time

20. Dominant Hand ☐ Right ☐ Left	21. What main or material duties of your job are you not able to perform as a result of your condition?

22. Date Symptoms First Appeared	23. Date of First Treatment	24. Hospital/Physician of First Treatment

25. This claim is for: ☐ Pregnancy ☐ Illness ☐ Accident	26. Nature of Illness	27. Have you previously suffered from this or a similar condition? ☐ No ☐ Yes, on Date Please Describe
	PLEASE PROVIDE A COPY OF THE INCIDENT OR ACCIDENT REPORT IF ONE IS AVAILABLE.	
	28. Date of Accident	29. Time of Accident : ☐ AM ☐ PM / 30. How & Where the Accident Occurred

31. Did the disabling accident occur while performing the duties of your job?
☐ No ☐ Yes (please explain)

32. Was your disability sustained in a Motor Vehicle Accident (MVA)? If so, what was your role in the accident?
☐ No, my disability is not the result of a MVA ☐ Yes, I was the driver ☐ Yes, I was a passenger

33. Was your disability sustained in an accident in which a third party was at fault?
☐ No ☐ Yes (please explain)

34. PLEASE LIST ALL PHYSICIANS YOU HAVE SEEN WITHIN THE LAST TWO YEARS. (USE AN ADDITIONAL SHEET OF PAPER IF NECESSARY)

Physician Name	Date Treated	Condition Treated	Address/City/State/Zip

35. OTHER INCOME YOU RECEIVED, FILED FOR OR ARE ELIGIBLE FOR. PLEASE INCLUDE A COPY OF YOUR AWARD OR DENIAL LETTER.

✓	Benefit Source	Gross Amount	Benefit Frequency	Date Applied For	Date Benefits Begin
☐	Workers' Compensation	$	☐ Weekly ☐ Monthly		
☐	State Disability/Leave	$	☐ Weekly ☐ Monthly		
☐	Social Security	$	☐ Weekly ☐ Monthly		
☐	Retirement/Pension	$	☐ Weekly ☐ Monthly		
☐	Unemployment	$	☐ Weekly ☐ Monthly		
☐	Other_____	$	☐ Weekly ☐ Monthly		

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EMPLOYEE STATEMENT (CONTINUED) - TO BE COMPLETED BY THE EMPLOYEE

IF YOU ARE OVERPAID BENEFITS AT ANY TIME DURING THE DURATION OF THIS CLAIM, A REQUEST FOR REIMBURSEMENT WILL BE MADE FOR THE OVERPAID AMOUNT. YOUR SIGNATURE ON THIS FORM AUTHORIZES RECOVERY OF ANY OVERPAID MEDICARE AND/OR SOCIAL SECURITY TAX THAT WAS PAID ON YOUR BEHALF AND CERTIFIES YOU WILL NOT ATTEMPT TO RECOVER A REFUND OR CREDIT OF THE MEDICARE AND/OR SOCIAL SECURITY TAX WITH ANY FORM W-2C THAT IS FURNISHED TO YOU BASED ON RECOVERIES RECEIVED. PLEASE LET US KNOW WHEN YOU RETURN TO WORK TO AVOID AN OVERPAYMENT. **PLEASE LET US KNOW WHEN YOU RETURN TO WORK TO AVOID AN OVERPAYMENT.**

36. SIGN & DATE BELOW

Employee Name Printed (First, MI, Last)	Employee Signature	Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, health care clearinghouse, insurance company, reinsurer, MIB, or consumer reporting agency ("providers") that has provided payment, treatment, or services to me to disclose the entire medical record and any other protected health information concerning me to USAble Life and its agents, employees, legal representatives, reinsurers, and the MIB. This includes information on the diagnosis of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information do not apply to this authorization, and I instruct any providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that USAble Life may:

1. administer claims and determine or fulfill responsibility for coverage and provision of benefits;
2. administer coverage; and
3. conduct other legally permissible activities that relate to any coverage I have or have applied for with USAble Life.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Customer Service, USAble Life, P.O. Box 9757, Portland, ME 04104-9757, or to claims@yourbenefitexpert.com. I understand that a revocation is not effective to the extent that any of the providers have relied on this authorization or to the extent that USAble Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the providers may not refuse to provide treatment if I refuse to sign this authorization. However, I further understand that if I refuse to sign this authorization to release complete medical records, USAble Life may deny my claim for benefits. I acknowledge that I have received a copy of this authorization.

SIGN & DATE BELOW

Employee Name Printed (First, MI, Last)	Employee Signature	Date
Claimant Name Printed (First, MI, Last) - *if other than Employee*	Claimant Signature - *if other than Employee*	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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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.

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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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EMPLOYER STATEMENT - TO BE COMPLETED BY THE EMPLOYER

✓ **CLAIM SUBMISSION CHECKLIST:** ☐ COPY OF ENROLLMENT CARD OR PROOF OF COVERAGE ☐ COPY OF EMPLOYEE'S JOB DESCRIPTION

1. Employee Name (First, MI, Last)	2. Date of Birth	3. Social Security Number
4. Mailing Address (Address, City, State, Zip)	5. Employee Contact Number 6. Occupation/Job Title	
7. Group Policy Number	8. Date of Hire	9. Employees Work State

10. Regular Number of Hours Worked _____ Per Week

11. Regular Days Worked ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

12. Current Pay ☐ Hourly/Rate $_____ ☐ Salaried/Amount $_____ ☐ Commissions/Total for 12 Months Prior to Disability $_____
☐ Other/Please Explain

13. Current Pay Effective Date	14. Coverage Benefit Amount $_____ Per Week	15. Coverage Effective Date	16. Employee Class Number or Description

17. Last Day Actively at Work _____ # of Hrs

18. Date Returned To Work ☐ Full-Time ☐ Part-Time

19. As the employer, would you be able to accommodate modified duty to facilitate early return to work?
☐ No ☐ Yes, Please explain (reduced hours, job modifications, etc)

20. PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES THE EMPLOYEE'S JOB DUTIES.

☐ Sedentary	☐ Light	☐ Medium	☐ Heavy	☐ Very Heavy	☐ Other
Lift negligible weight Mostly sitting	Lift up to 10 lbs frequently; up to 20 lbs occasionally And/or frequently walk/ stand and/or push/pull	Lift up to 25 lbs frequently; up to 50 lbs occasionally	Lift 25 to 50 lbs frequently; 50 to 100 lbs occasionally	Lift over 50 lbs frequently; 100 lbs occasionally	Please describe

21. OTHER INCOME PAID AFTER EMPLOYEE'S LAST DAY WORKED (PLEASE CHECK & COMPLETE ALL THAT APPLY.) ☐ NONE

Pay Source	Weekly Amount	Paid-Through Date
☐ Sick Pay	$_____	
☐ Vacation/PTO	$_____	
☐ Salary Continuation	$_____	
☐ Commissions	$_____	
☐ State/Disability Leave	$_____	
☐ Other	$_____	

Has a Workers' Compensation claim been filed or expected to be filed?
☐ No ☐ Yes, please provide a copy of the first injury report.

Name and Address of Workers' Compensation Carrier:
_____
_____
_____
_____

IMPORTANT: PLEASE CONTACT YOUR PAYROLL OR HUMAN RESOURCES DEPARTMENT FOR THE FOLLOWING INFORMATION.

22. Total Year-to-Date Social Security Wages Paid: $_____ as of Date:

23. Total Year-to-Date Medicare Taxable Wages Paid: $_____ as of Date:

24. What percentage of the STD premium is paid by the Employer: _____%

25. What percentage of the STD premium is paid by the Employee: _____%

Percentages in 22. and 23. must add up to 100%.

26. Are Employer-paid premiums included in the Employee's taxable wages/salary? ☐ Yes ☐ No ☐ N/A

27. Are Employee-paid premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? ☐ Yes ☐ No

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EMPLOYER STATEMENT - TO BE COMPLETED BY THE EMPLOYER

⚠ **FRAUD WARNING:** 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.

28. Employer Name	29. Employer Mailing Address (Address, City, State, Zip)	
30. Contact Name	31. Contact Phone Number	
32. Contact Fax Number	33. Contact Email Address	
34. Contact Signature	35. Contact Title	36. Date

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ATTENDING PHYSICIAN STATEMENT - TO BE COMPLETED BY THE PHYSICIAN

1. Patient Name (First, MI, Last)	2. Date of Birth
3. Mailing Address (Address, City, State, Zip)	4. Height
	5. Weight
6. Disabling Diagnosis and Concurrent Conditions	7. ICD Code 1. 2.

8. This disability is due to: ☐ Accident ☐ Illness ☐ Pregnancy	9. Is this condition the result of a work-related injury or illness? ☐ No ☐ Yes, please explain _____
10. If disability is due to an accident, how & where did the accident occur?	

11. If disability is due to pregnancy: Date of LMP	Delivery Date ☐ Actual ☐ Estimated	Type of Delivery ☐ Vaginal ☐ C-Section

12. Date Symptoms First Appeared	13. Date of First Visit for Current Condition	14. Date of Next Appointment	15. Date of Most Recent Visit

16. What date was the patient first unable to work due to disability?
17. What date did you first discuss the possibility of the patient being unable to continue working due to disability?
18. In your opinion, on what date will/did the patient recover sufficiently to return to work?
19. Has the patient ever had the same or similar condition? ☐ No ☐ Yes, on what date?
20. Please list all treatment dates during the month the disability began.
21. Did another physician treat/or will be treating the patient? ☐ No ☐ Yes, on what date?

22. Other Physician Name	23. Other Physician Phone Number
24. Please list the dates and types of surgical procedures related to this condition.	
25. Were there any complications that caused your patient to stop working prior to the expected surgery or delivery? ☐ No ☐ Yes, please explain	

26. Was your patient hospitalized? ☐ No ☐ Yes	☐ Inpatient ☐ Outpatient	Date Admitted	Date Discharged
27. Full Hospital Name			

28. Hospital Address	29. Hospital Phone Number

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ABILITIES - TO BE COMPLETED BY THE PHYSICIAN

Address the full range of restrictions/limitations based on your medical findings at the time patient stopped working or reduced work schedule, noting that we will assume there are no restrictions on function unless specified below.

In a general workplace environment the patient is able to:

	Sit	Stand	Walk
Number of hours at a time			
Total hours/day			
Check here if no restrictions	☐	☐	☐

Please check the frequency with which the patient can perform the following activities:

R = Right L = Left B = Bilateral		No Restrictions	Frequently (34%-67%)	Occasionally (1%-33%)	Never
Lift/carry 1 to 10 lbs.		R L B	R L B	R L B	R L B
Lift/carry 11 to 20 lbs.		R L B	R L B	R L B	R L B
Lift/carry 21 to 30 lbs.		R L B	R L B	R L B	R L B
Lift/carry 31 to 40 lbs.		R L B	R L B	R L B	R L B
Lift/carry 41 to 50 lbs.		R L B	R L B	R L B	R L B
Lift/carry 51 to 100 lbs.		R L B	R L B	R L B	R L B
Lift/carry over 100 lbs.		R L B	R L B	R L B	R L B
Bending at waist					
Kneeling/crouching					
Driving					
Reaching only (non-load-bearing)	Above shoulder	R L B	R L B	R L B	R L B
	Below shoulder level (reach forward for objects on desktop or workstation)	R L B	R L B	R L B	R L B
Fingering/handling		R L B	R L B	R L B	R L B

Hand dominance: ☐ Right ☐ Left

Progress (please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Expected duration of any restriction(s) or limitation(s) listed above:

Additional Comments:

Does the patient have a psychiatric/cognitive impairment? ☐ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology:

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

What is the planned course and duration of treatment, including medications?

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Are you related to this patient? ☐ No ☐ Yes, what is the relationship?		
Attending Physician's Name (please print or type):		Telephone Number:
License Number:	EIN Number:	Fax Number:
Degree:	Specialty:	
Address: (Street, City, State, and ZIP Code)		
Signature:		Date Signed: