



Attention: Claims Department  
 P.O. Box 1650  
 Little Rock, Arkansas 72203-1650  
 Telephone (501) 375-7200 Fax (501) 399-3806

# Statement of Claim Short Term Disability Income Benefits

For H.O. Use Only	
Eff	_____
PTD	_____
Benefits	_____

### Instructions

1. Please make sure all questions on Employee's Statement are completed in full.
2. Authorization must be signed and currently dated.
3. Employer's & Physician's Statements on Page 2 (reverse side) must be completed.
4. Mail the completed claim form to USABLE Life. If faxing the completed claim form, the original must also be mailed.

### EMPLOYEE'S STATEMENT

Full Name (Last, First)		Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		Date of Birth	Occupation	
City, State, Zip Code		Telephone Numbers	Home ( )	Work ( )
Claim is for <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy		Nature of Accident or Sickness		
Date of 1st Treatment	Physician or Hospital First Treated By		First Full Day of Disability	
If accident, how did the accident occur? _____				
Accident Date _____ Time _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Place _____				
Names and addresses of all doctors consulted for <b>this</b> condition (Use separate sheet if necessary):				
Physician	Date Treated/Consulted	Address, City, State and Zip Code		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
Have you ever had this or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give particulars: Date _____				
Describe _____				
Names and addresses of all doctors seen for <b>any</b> condition in the past five years (Use separate sheet if necessary):				
Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
<b>Authorization to Obtain Information</b>				
I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state, or local), Social Security Administration, or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USABLE Life (or its representatives) and to permit them to examine and copy any such information. I understand that USABLE Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company. A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge I have a right to a copy of this authorization upon request.				
<b>WARNING:</b> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.				
_____		_____		
Date		Employee's Signature		

Please have your Employer and Attending Physician complete page 2 (reverse side).

## ATTENDING PHYSICIAN'S STATEMENT (APS)

**\*\* Neither the Employee nor the Employer should complete or alter any part of the APS. \*\***

Patient's Full Name _____		Date of Birth _____	
Diagnosis & Concurrent Conditions 1. _____ 2. _____		ICD Codes 1. _____ 2. _____	
Disability is due to <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy If accident, provide how, when and where accident occurred _____ _____ _____ If Pregnancy, _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated Delivery Date _____ Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section _____ Date Symptoms First Appeared _____ Date Patient First Consulted You _____ Dates & Surgical Procedures (if any) _____ _____ If hospitalized, <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Admitted _____ Date Discharged _____ Full Name of Hospital _____ Address _____ City, State, Zip Code _____ _____ Telephone # of Hospital _____		Did disability arise from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ How long was or will patient be unable to work due to disability? From _____ Through _____ Can return to work on _____ Please list all treatment dates during the month in which the disability began _____ _____ _____ Date of next doctor's appointment _____ _____ List Restrictions and Limitations _____ _____ _____ _____ Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes    Date _____ Describe any circumstances causing disability to be prolonged: _____ _____ _____	

Physician's Signature _____		Provider Tax ID # _____	Date _____
Physician's Name (Please Print/Type) _____		Degree _____	
Address _____		Telephone ( ) _____	
City _____	State _____	Zip Code _____	Fax ( ) _____

**Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.**

## EMPLOYER'S STATEMENT

Group Policy Number _____	Employee Social Security No. _____	Date of Hire _____	Coverage Effective Date _____	Weekly STD Benefit \$ _____
Last Day Worked Date _____ # of Hours _____	Date Returned to Work: <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____	Base Salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	Employee Regularly Works _____ Hours Per Week Employee Regularly Works Weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Employee received:    Salary continuation through _____    Vacation pay through _____    Sick pay through _____				
Employer Name _____			Tax ID # _____	
Signature _____		Title _____	Date _____	
Name (Please print or Type) _____		Telephone ( ) _____	Fax ( ) _____	
Street Address _____		City _____	State _____	Zip Code _____

## **FRAUD NOTICE**

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

### **Arizona**

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

### **California**

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

### **Florida**

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

### **New Jersey**

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

### **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.

Retain for your records.