Colonial Life

Continuing Disability Claim Form

Fax this direction.

Fax to: Claims 1.866.887.6644
From:_____
Number of pages:_____

Mail to:
P.O. BOX 100195
Columbia SC 29210
Questions? Call **1.800.325.4368** • 24 Hours A Day / 7 Days a Week

(Do Not Use this Form if this is the first time you are filing for this injury or sickness)
If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

Section 1 TO BE COMPLETED BY POLICY OWNER

Claimant name __Male __Female	**Birth Date**	**Claimant Social Security Number**
Mailing Address (Street or PO Box)		**Apartment/Unit/Lot Number**
(City) (State) (Zip)		**Home telephone**
Policy owner e-mail address		**Work telephone**
Claim is for: ____Accident _____Sickness	**Condition that keeps you from working**	
Date the accident occurred (not when it was treated)	**Description of accident**	
Were you at work at the time of your accident or sickness? ____Yes ____No	**Dates unable to work: From_____ (MM/DD/YYYY) To_____ (MM/DD/YYYY)**	

Have you been unable to perform any activities of daily living? ___Yes ___No
If yes, please list the dates you were unable to perform the activities: From _____ (MM/DD/YYYY) To_____ (MM/DD/YYYY)

Check the activities that you are unable to perform:
__dressing __eating __meal preparation __toileting __continence __ bathing __ transferring

If not employed, list dates of house confinement: From_____ (MM/DD/YYYY) To_____ (MM/DD/YYYY)	**House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.**

Date you returned to work: Full-time_____ (MM/DD/YYYY) Part-time_____/Hours worked per week_____ (MM/DD/YYYY)

Section 2 TO BE COMPLETED BY EMPLOYER(s)

Dates employee unable to work (Full-time) From_____ AM/PM (MM/DD/YYYY) To_____ AM/PM (MM/DD/YYYY)	**Was employee at work when the accident or sickness occurred? ___Yes ___No**
Date returned to work: Full-time_____ AM/PM (MM/DD/YYYY) Part-time_____ AM/PM/Hours per week_____ (MM/DD/YYYY)	**Employee job title**
Expected return to work _____ (MM/DD/YYYY)	**Who should we contact for updates on return to work status? Name/Phone/Email**

<u>FRAUD NOTICE</u>: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Signed by_____ **Title**_____

Print name _____ **Date**_____

Telephone Number( )_____**Fax Number( )**_____

Email Address:

46988-22

Claim Fraud Statements

For your protection, the laws of several states, including **Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma**, and others require the following statement to appear on this claim form. **Fraud Warning :** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

Arizona Residents : 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.

California, Rhode Island, Texas and West Virginia Residents : For your protection, California, Rhode Island, Texas and West Virginia law requires the following to appear on this form: 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 Residents : 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.

District of Columbia: 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.

Florida Residents : 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.

Kentucky : For your protection, Kentucky law requires the following to appear on this form: 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.

Maine, Tennessee, Virginia and Washington Residents : 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.

Maryland Residents : 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.

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

New York Residents : 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 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.

Pennsylvania Residents : 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

Oregon Residents : Any person who, knowingly and 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 that is relied upon by the insurer and is material to the content of the policy and to the risk assumed by the insurer, may be prosecuted for insurance fraud. There is no time limit on contestability in the event of fraud on the part of the insured.

Puerto Rico Residents : Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years

Section 3 TO BE COMPLETED BY PHYSICIAN

Patient's name	**Patient's DOB**
What primary condition prevents the patient from working?	
Symptoms: **Objective Findings:**	
Date first treated for this condition_____ (MM/DD/YYYY)	**If pregnancy, what is EDC? _____ (MM/DD/YYYY)**
Is condition due to accident? ____Yes ____No If yes, date and description of accident.	
Are any secondary conditions preventing the patient from working? ___Yes ___No	**If yes, what are these secondary conditions?**

When did symptoms first appear? _____ (MM/DD/YYYY)	**Date of new patient consultation _____ (MM/DD/YYYY)**	**Date of patient's last visit. _____ (MM/DD/YYYY)**
List any test(s) performed and submit a copy of the results.	**List any surgeries performed with the date and procedure code.(CPT) (Attach a copy of the operative report)**	
Restrictions (What the patient SHOULD NOT DO)		
Limitations (What the patient CANNOT DO)		
How soon do you expect significant improvement in the patient's medical condition? _____1-2 months _____3-4 months _____5-6 months _____more than 6 months		**Expected return to work_____ (MM/DD/YYYY)**
Dates unable to work (full-time): From:_____ To:_____ (MM/DD/YYYY) (MM/DD/YYYY)	**Dates unable to work (part-time): From:_____ To:_____ (MM/DD/YYYY) (MM/DD/YYYY)**	**Actual date released to return to work _____ (MM/DD/YYYY)**
Does this patient have permanent restrictions/limitations? ___Yes ___No	**If not employed, list dates of house confinement: From_____ To_____ (MM/DD/YYYY) (MM/DD/YYYY)**	**House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.**
Please check the activities of daily living that the patient is unable to perform: __dressing __eating __meal preparation __toileting __continence __ bathing __ transferring		
Date(s) of office visit (Last 3 Months)		**How often do you see the patient?**
Have you referred patient for other types of consultations? _____Yes _____No		**Name and address of Specialist**
Dates of Hospitalization (Last 3 months)		**Name and Address of Hospital**

<u>FRAUD NOTICE</u>: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

Signature of Physician	**Date_____ (MM/DD/YYYY)**	**Physician's Specialty**
Telephone number ( )	**Fax Number ( )**	**Tax ID or SSN**
Physician/Group Name		**Patient Account Number**
Mailing Address		**Do you accept Medical Records request by Fax? ____Yes ____No**
Was patient referred to you by another physician? _____Yes_____No		**Do you have authorization on file to release information to Colonial Life? ____Yes ____No**
Provide the following information for referring doctor. Name:		**Phone number**
Address		**Fax**
Policy Owner		**Policy Owner Social Security Number**

- **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**
- **If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

CERTIFICATION

Policy owner's Name_____ **Social Security #**_____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page 2 of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. **Fraud Warning: 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.**

X_____ X _____ X _____

Claimant's Signature Policy owner's Signature Date (MM/DD/YYYY)

Fax this direction.