USAble Life℠

300 Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
Fax: (207) 766-3448
E-mail: claims@disabilityrms.com

Educator Disability Plan
Instructions for Filing Claims

Dear Insured:

USAble Life is pleased to provide you coverage when you are unable to work due to a covered disability. We have included these instructions and the necessary forms to assist you in the event you need to file a claim for disability benefits. Please remember that all forms must be received within 90 days of the date you stop work.

Employee Statement

1. Complete the Employee Statement in full.
2. Answer all questions or state "not applicable".
3. Review the attached Fraud Statement as it applies to your state of residence, sign and date.
4. Sign and date the Authorization form.

Employer & Attending Physician Statements

1. Obtain the statement of your Attending Physician who will certify your disability.
2. Obtain the statement of your Employer.

Return All Forms to USAble Life:

Facsimile: (207) 766-3448

E-mail: claims@disabilityrms.com

Mail: 300 Southborough Drive, Suite 200, South Portland, ME 04106

For Questions or Assistance Call or Contact USAble Life:

Telephone: (877) 254-0085

USAble Life℠

Attention: Claims Department
300 Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
Fax: (207) 766-3448
E-mail: claims@disabilityrms.com

Statement of Claim
Educator Disability Plan
Income Benefits
Employee's Statement

Instructions

1. **Please type or print in blue or black ink.**
2. **Please make sure all questions on Employee's Statement are completed in full.**
3. **Employer's and Physician's Statements must be completed.**
4. **Authorization and Fraud Notice must be signed and currently dated.**
5. **Email, fax or mail the completed form to USAble Life.**

EMPLOYEE'S STATEMENT

Full Name (First, Middle, Last)	Social Security Number	Gender ☐ Male ☐ Female
Street Address	Date of Birth	Occupation
City, State, Zip	Telephone Numbers Home / Work	
Claim is for ☐ Accident ☐ Sickness ☐ 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 _____ ☐ A. M. ☐ P.M. Place _____

Was a third party responsible for accident? ☐ Yes ☐ No If Yes, third party's name _____

Third party's address _____

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement) ☐ Yes ☐ No $_____ Mo. V.A. Benefits: ☐ Yes ☐ No $_____ Mo.
Dependent Social Security: ☐ Yes ☐ No $_____ Mo. Worker's Compensation: ☐ Yes ☐ No $_____ Wk.
Retirement: (normal, early or disability) ☐ Yes ☐ No $_____ Mo. Other Disability Coverage: ☐ Yes ☐ No $_____ Wk.
Unemployment: ☐ Yes ☐ No $_____ Wk. (identify)_____

Include a copy of your award or denial letter for any source in which one has been received.

Names and addresses of all doctors consulted for **this** 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? ☐ Yes ☐ No If yes, give particulars: Date _____

Describe_____

Names and addresses of all doctors seen for **any** condition in the past five years (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition

USAble Life℠

Attention: Claims Department 300
Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
Fax: (207) 766-3448
E-mail: claims@disabilityrms.com

Statement of Claim
Educator Disability Plan
Income Benefits
Attending Physician's Statement

Instructions

1. **Physician certifying disability must complete all questions, sign and date this Attending Physician's Statement.**
2. **Fax or mail the completed form to USAble Life.**

ATTENDING PHYSICIAN'S STATEMENT

Neither the Employee nor the Employer should complete or alter any part of this statement.

Patient's Full Name (First, Middle, Last)	Date of Birth

Diagnosis & Concurrent Conditions	ICD Codes
1.	1.
2.	2.

Disability is due to
☐ Accident ☐ Sickness ☐ Pregnancy
If accident, provide how, when and where accident occurred _____
_____
_____

If Pregnancy, _____ ☐ Actual ☐ Estimated
Delivery Date
Date of LMP _____
Type of Delivery ☐ Vaginal ☐ C-section
_____

Date Symptoms First Appeared _____
Date Patient First Consulted You _____
Dates & Surgical Procedures (if any) _____
_____
_____

If hospitalized, ☐ Inpatient ☐ Outpatient
Date Admitted_____ Date Discharged _____
Full Name of Hospital _____
Address _____
City, State, Zip Code _____
_____
Telephone # of Hospital _____

Is Disability due to injury or sickness arising out of or in the course of patient's employment? ☐ Yes ☐ 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?
☐ No ☐ Yes Date _____

Describe any circumstances causing disability to be prolonged:

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

FRAUD WARNING: Except as noted in the Fraud 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.

USAble Life℠

Attention: Claims Department
300 Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
Fax: (207) 766-3448
E-mail: claims@disabilityrms.com

Statement of Claim
Educator Disability Plan
Income Benefits
Employer's Statement

Instructions

1. **Employer must complete all questions, sign and date this Employer's Statement.**
2. **Fax or mail the completed form to USAble Life.**

EMPLOYER'S STATEMENT

Employee Name (First, Middle, Last)		Date of Birth	Social Security Number
Group Policy Number	Date of Hire	Coverage Effective Date	Monthly LTD Benefit $

Last Day Worked	Date Returned to Work	Base Salary $ _____
Date _____ # of Hours _____	☐ Full-Time _____ ☐ Part-Time_____	☐ Hourly ☐ Monthly ☐ Weekly ☐ Annually

Employee Regularly Works _____ Hours Per Week	Employee's Occupation

Check Days Normally Worked?	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat

If on rotation, give number of days worked per week: _____

Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? ☐ Yes ☐ No

If yes, Status of claim? ☐ Pending ☐ Approved ☐ Denied ☐ Denial on Appeal

Name of Worker's Compensation Carrier: _____

Address of Worker's Compensation Carrier: _____

_____

Employee received: Salary continuation through _____ Vacation pay through _____ Sick pay through _____

Employer Name	Email address	Tax ID #
Signature	Title	Date
Name (Please print or Type)	Telephone	Fax

Street Address City State Zip Code

FRAUD WARNING: Except as noted in the Fraud 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.

USAble Life℠

FRAUD NOTICE

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.

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

CA Residents Only: 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 Residents Only: 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, ID, IN, OK Residents Only: 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 Residents Only: 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 Residents Only: 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 of the third degree.

KS Residents Only: 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 as determined by a court of law.

KY Residents Only: 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 and TN Residents Only: 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 and denial of insurance benefits.

MD, RI, TX Residents Only: 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 Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

OH Residents Only: 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.

OR Residents Only: 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 Residents Only: 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.

VT Resident Only: 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.

VA and WA Residents Only: 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.

_____ _____

Date Signature

USAble Life℠

300 Southborough Drive, Suite 200
South Portland, Maine 04106-6914
Telephone: (877) 254-0085
Fax: (207) 766-3448
E-mail: claims@disabilityrms.com

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)

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 non-medical information about me, (including any information, data or records regarding my Social Security, FICA earnings history, Worker's 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 **HIV/AIDS*** information) which 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 (2) 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 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 Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (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 Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are 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.

Claimant Name: _____ Date of Birth: _____

Claimant Signature (or Authorized Representative): _____ Date: _____

Description of Personal Representative's Authority (If applicable):
(*If signed by authorized representative, attach verification of identity)