Continental American Insurance Company
PO Box 427, Columbia, SC 29202
Phone: 1-866-849-0011 Fax: 1-866-849-2970

Short-Term Disability Claim Form Instructions

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1. **Complete Claimant's Statement:**

    - Sections I and II (To be completed by the Employee). Please be sure to also sign and date the medical authorization section.
    - Review your portion of the claim form for completeness.

2. **Have your Health Care Provider complete Page 2 of this form (Attending Physician Statement).**

    - Do not complete any portion of this section yourself.

3. **Once the entire form has been completed, please mail or fax it to:**

    Continental American Insurance Company
    P.O. Box 427
    Columbia, SC 29202

    Fax: 1-866-849-2970

4. As part of the claims process, CAIC will need to confirm your dates out of work. CAIC will confirm these dates with your union. **No action is required on your part for this process.**

If you have any questions regarding the material enclosed, please contact Continental American's Customer Service Department Monday through Friday from 8 a.m. to 8 p.m. Eastern Time at 1-866-849-0011.

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UNITED AIRLINES AFA
SHORT TERM DISABILITY CLAIM FORM

CLAIMANT'S STATEMENT • PLEASE READ THE INSTRUCTIONS BEFORE COMPLETING

PERSONAL DATA – SECTION I

NAME (Last, First, Middle Initial)		SOCIAL SECURITY NO.	EMPLOYEE ID	
ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH	GENDER ☐ M ☐ F	PHONE NUMBER	EMAIL ADDRESS*	

CLAIM DATA – SECTION II

DESCRIBE HOW AND WHERE THE ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS	WHAT WERE YOUR FIRST SYMPTOMS?
IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION ☐ NO ☐ YES IF YES, DATE REPORTED TO EMPLOYER:	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ NO STATUS ☐ YES ☐ APPROVED ☐ PENDING ☐ DENIED

DATE YOU WERE FIRST TREATED FOR YOUR ILLNESS OR INJURY

TREATED BY:

Doctor: _____
Name Street Address City State Zip Code

_____
Phone Numer Fax Number Email

Hospital/Clinic: _____
Name Street Address City State Zip Code

_____
Phone Numer Fax Number Email

AUTHORIZATION TO OBTAIN

Several states require that the following statement appear on the claim forms:

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 loss is guilty of a crime and may be subject to fines and confinement in state prison.

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate or administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

Claimant's Signature: Date:

**By providing your email address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or account to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be legally required to deliver to you).*

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UNITED AIRLINES AFA
SHORT TERM DISABILITY CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT (To be completed by your current treating physician)

PATIENT'S NAME		DATE OF BIRTH
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	DATE PATIENT CEASED WORK BECAUSE OF DISABILITY?	HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐YES ☐ NO DATE:
IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENTS EMPLOYMENT? ☐ NO ☐ YES IF "YES," DATE ACCIDENT OCCURRED: _____.	NAMES AND ADDRESSES/ REFERRING OR OTHER TREATING PHYSICIANS	

DIAGNOSIS

DIAGNOSIS (INCLUDING COMPLICATIONS)	ICD CODE:	SUBJECTIVE SYMPTOMS	IF PREGNANT (EDC):
OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS.)			

TREATMENT

DATE FIRST TREATED FOR THIS CONDITION	LAST DATE TREATED FOR THIS CONDITION	FREQUENCY ☐ WEEKLY ☐ MONTHLY ☐ OTHER
NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)	DID PATIENT HAVE SURGERY? ☐ NO ☐ YES DATE: DESCRIBE SURGERY:	

PROGNOSIS

HAS THE PATIENT: ☐ RECOVERED? ☐ IMPROVED? ☐ UNCHANGED? ☐ RETROGRESSED?	IS THE PATIENT: ☐ AMBULATORY? ☐ HOUSE CONFINED? ☐ BED CONFINED? ☐ HOSPITAL CONFINED?
HAS THE PATIENT BEEN HOSPITAL CONFINED? ☐ NO ☐ YES CONFINED FROM_____TO_____.	IF YES, GIVE NAME AND ADDRESS OF HOSPITAL:
IS THE PATIENT NOW TOTALLY DISABLED FROM? PATIENT'S JOB? ☐ NO ☐ YES ANY OTHER WORK? ☐ NO ☐ YES	DATE PATIENT BECAME DISABLED DUE TO PRESENT CONDITION?
WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION? ☐ 1 MO. ☐ 1-3 MO. ☐ 3-6 MO. ☐ 6-9 MO. ☐ 9-12MO. ☐ NEVER	WHEN DO YOU ANTICIPATE A RETURN TO WORK?

IMPAIRMENTS

PHYSICAL IMPAIRMENTS (As defined in the Federal Dictionary of Occupational Titles)

☐ CLASS 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%)

☐ CLASS 2 - Medium manual activity. (15-30%)

☐ CLASS 3 - Slight limitation of functional capacity; capable of light work. (35-55%)

☐ CLASS 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)

☐ CLASS 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity (75-100%)

RESTRICTIONS AND LIMITATIONS (What specific activities is the patient incapable of performing)

REMARKS

REMARKS (Additional comments regarding the patient's condition)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

NAME (Attending Physician) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: 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.

ARKANSAS: 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.

CALIFORNIA: 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.

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.

DELAWARE: 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.

DISTRICT OF COLUMBIA: 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.

FLORIDA: 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.

IDAHO: 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.

INDIANA: 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.

KENTUCKY: 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.

LOUISIANA: 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.

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

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: 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.

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

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: 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.

NEW YORK: 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.

OHIO: Any person who, 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 is guilty of insurance fraud.

OKLAHOMA: **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, 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 may be guilty of insurance fraud.

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.

PUERTO RICO: 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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should 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.

TENNESSEE: 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.

TEXAS: 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.

VIRGINIA: 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.

WASHINGTON: 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.

RHODE ISLAND and WEST VIRGINIA: 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.

ALL OTHER STATES: 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.