

Short-Term Disability Claim Form Instructions

1. Complete Claimant sections:

- 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. Employment Information

- This is needed to verify the dates that you were unable to work due to your disability.
- This can be completed by your supervisor or union representative.

4. 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

Once Continental American Insurance Company has received the form, a claims representative will contact you to discuss your claim for benefits.

If you have any questions regarding the materials enclosed, please contact Continental American's Customer Service Department Monday through Friday from 8 a.m. to 5 p.m. Eastern Time at 1-866-849-0011.

**Continental American
Insurance Company**
Post Office Box 427
Columbia, South Carolina 29202
Phone (866) 849-0011

**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	SEX <input type="checkbox"/> M <input type="checkbox"/> 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 IF YES, DATE REPORTED TO EMPLOYER: <input type="checkbox"/> NO <input type="checkbox"/> YES		HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DATE YOU WERE FIRST TREATED FOR YOUR ILLNESS OR INJURY	TREATED BY:			
	Doctor:	Name	Street Address	City State Zip Code
		Phone Number	Fax Number	Email
	Hospital/Clinic:	Name	Street Address	City State Zip Code
		Phone Number	Fax Number	Email

EMPLOYMENT DATA – SECTION III (To be completed by your Manager or Union Representative)

EMPLOYER'S NAME	SUPERVISOR/MANAGER/UNION REP.	PHONE NUMBER (WORK)	EMPLOYEE OCCUPATION
DATES EMPLOYEE DID NOT WORK FROM THROUGH	SUPERVISOR/MANAGER/UNION REP. SIGNATURE	DATE	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? <input type="checkbox"/> NO <input type="checkbox"/> YES

AUTHORIZATION

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 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:

**Continental American
Insurance Company**
Post Office Box 427
Columbia, South Carolina 29202
Phone (866) 849-0011

**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? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE:
IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENT'S EMPLOYMENT? <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER
NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)		DID PATIENT HAVE SURGERY? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: DESCRIBE SURGERY:

PROGNOSIS

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

IMPAIRMENTS

PHYSICAL IMPAIRMENTS (As defined in the Federal Dictionary of Occupational Titles) <input type="checkbox"/> CLASS 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%) <input type="checkbox"/> CLASS 2 - Medium manual activity. (15-30%) <input type="checkbox"/> CLASS 3 - Slight limitation of functional capacity; capable of light work. (35-55%)	<input type="checkbox"/> CLASS 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%) <input type="checkbox"/> 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#	