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 no 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

SHORT TERM DISABILITY CLAIM FORM

PERSONAL DATA – SECTION I

NAME (Last, First, Middle Initial) ______________________________

SOCIAL SECURITY NO. ___________________________

EMPLOYEE ID __________________________

ADDRESS ________________________________

CITY __________________________

STATE __________________________

ZIP CODE __________________________

DATE OF BIRTH __________________________

SEX 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?

YES NO

DATE YOU WERE FIRST TREATED FOR YOUR ILLNESS OR INJURY __________________________

TREATED BY: __________________________

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 ______/____/____ TO ______/____/____

SUPERVISOR/MANAGER/UNION REP. SIGNATURE __________________________

DATE __________________________

HAS A WORKER’S COMPENSATION CLAIM BEEN FILED?

NO 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: __________________________
# SHORT TERM DISABILITY
## CLAIM FORM

**Continental American Insurance Company**

**Post Office Box 427**

**Columbia, South Carolina 29202**

**Phone (866) 849-0011**

## ATTENDING PHYSICIAN’S STATEMENT

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
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</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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 patient's employment? No | Yes | If “Yes,” date accident occurred:

**Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis (including complications)</th>
<th>ICD Code</th>
<th>Subjective Symptoms</th>
<th>If pregnant (EDC):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings.)

**Treatment**

<table>
<thead>
<tr>
<th>Date first treated for this condition</th>
<th>Last date treated for this condition</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Weekly</td>
</tr>
</tbody>
</table>

Nature of treatment (surgery and medications prescribed, if any.) Did patient have surgery? No | Yes | Date:

Describe surgery:

**Prognosis**

<table>
<thead>
<tr>
<th>Has the patient:</th>
<th>Improved?</th>
<th>Unchanged?</th>
<th>Retrogressed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovered?</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Has the patient been hospital confined? No | Yes | 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. | 9-12 mo. | Never

When do you anticipate a return to work?

**Impairments**

<table>
<thead>
<tr>
<th>Physical impairments (as defined in the Federal Dictionary of Occupational Titles)</th>
<th>Restrictions and limitations (what specific activities is the patient incapable of performing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%)</td>
<td>Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (60-70%)</td>
</tr>
<tr>
<td>Class 2 - Medium manual activity. (15-30%)</td>
<td>Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity (75-100%)</td>
</tr>
<tr>
<td>Class 3 - Slight limitation of functional capacity; capable of light work. (25-55%)</td>
<td></td>
</tr>
</tbody>
</table>

**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.**

<table>
<thead>
<tr>
<th>Name (Attending Physician)</th>
<th>Degree</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Address**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
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<tr>
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**Signature**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medical ID#</th>
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