Fax to: Claims 1.800.880.9325

From:_____

Fax Number:_____

Date:_____

Number of pages:_____

Disability Claim Form and Instructions

Colonial Life℠

Making benefits count.

Your disability must be filed within 12 months of your date of loss unless you are legally unable to do so.

What can I do to avoid delays?

Missing information will delay the processing of your claim.

- **Complete** Section 1.
- **Sign** and **return** the Authorization. (Reverse side of page 3)
- **Sign** and **return** the Certification on page 3.
- Have your doctor and employer complete their sections.
- Enclose copies of all bills connected with your claim, if applicable.

When should I expect a reply?

- If you are filing a claim for a sickness or health condition occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to determine if the condition is pre-existing. We may have to write for this information which may delay your claim. **Please include the signed authorization with your claim and ask your doctor to promptly respond to our request for medical information.**

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way.

To avoid mail delays:

- **Fax** your claim to us at **1.800.880.9325**. **If you fax your claim, please do not mail the original document but keep it for your records.** Please allow **at least 48 hours** for our automated service center to be updated with information confirming receipt of your fax.
- Have your payment returned by **overnight delivery** by initialing the Service Release below. An $18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments of $100.00 or more. Payments will not be overnighted to P.O. Box addresses. Your check will be delivered Monday through Friday; however, the time is not guaranteed.**

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.

I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by releasing its details if he/she is inquiring on my behalf.

_____ local sales representative (initial)

_____ plan administrator (initial)

_____ spouse, family member or significant other (initial)

_____ (initial) I authorize Colonial Life & Accident Insurance Company to communicate information on the status of this claim through **electronic messaging** at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine. I will program phone number 1.800.325.4368 into my phone to avoid calls being blocked.

_____ (initial) Yes, please deduct the $18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from my claim payment for this claim. This fee does not include weekend delivery. I understand this fee will be deducted for **future payments** for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under $100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying Colonial Life in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by us.

CLAIMANT NAME:_____ **SOCIAL SECURITY NUMBER:**_____

FAX TO 1.800.880.9325
Questions? Call 1.800.325.4368 • 24 Hours A Day/7 Days a Week

OR YOU MAY MAIL TO:
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
Attn.: DISABILITY BENEFITS
P. O. BOX 100195
COLUMBIA, SOUTH CAROLINA 29202-3195

Colonial Life℠
Making benefits count.

SECTION 1	**TO BE COMPLETED BY POLICYOWNER**		
1. Policyowner name Patient Name ☐ Male ☐ Female		If the address given at left has changed since your last claim please mark box with an "x". ☐	
Address (Street Required for Overnight)		Policy Number	
City State Zip Code		Social Security Number	Birthdate (MM/DD/YYYY)
Policyholder Email Address			
2. Claim is for: ☐ Accident ☐ Sickness		Home Telephone ( )	Work Telephone ( )
3. Date and Description of Injury/Sickness		Were you at work at the time of your injury/sickness? ☐ Yes ☐ No	
4. List dates (MM/DD/YYYY) unable to work From: To:		If not employed, list dates (MM/DD/YYYY) of house confinement*: From: To:	
5. Have you returned to your place of employment? ☐ Yes, ☐ No ☐ Full-time ☐ Part-time	Date Returned to Work (MM/DD/YYYY)	*house confinement means unable to do normal daily activities	

6. List all doctors who have treated you for this condition and include your primary care physician's name first.

Doctor's name	Phone Number	Address
1.		
2.		
3.		
4.		

SECTION 2 TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR			
7. Dates (MM/DD/YYYY) Employee unable to work From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.		Date Employee returned to his/her primary duties Date MM/DD/YYYY) ☐ a.m. ☐ p.m. ☐ Part-time ☐ Light Duty ☐ Full-time	
8. Employee's Job Title		Employee's Salary Monthly Hourly	
Employee's duties include:			
Lifting	☐ less than 15 lbs.	☐ 15 to 44 lbs.	☐ over 45 lbs.
Stooping/bending	☐ none	☐ seldom	☐ frequent
Crawling/climbing/kneeling	☐ none	☐ seldom	☐ frequent
Reaching/pulling/pushing	☐ none	☐ seldom	☐ frequent
Repetitive	☐ none	☐ seldom	☐ frequent
Management duties	☐ none	☐ seldom	☐ frequent
Sitting (Number of hours each day): _____			
Standing/Walking (hours each day): _____			
9. If injured, did the loss occur while the employee was at work? ☐ Yes ☐ No If yes, date _____.			
10. Signed by _____ Title _____			
Date (MM/DD/YYYY) _____ Employer's Telephone Number ( ) _____			
Employer's Email Address _____ Employer's Fax Number ( ) _____			

SECTION 3 TO BE COMPLETED BY PHYSICIAN

11. What is this patient's current primary disabling condition? _____

Symptoms: _____ Objective Findings: _____

If pregnancy, what is the EDC? _____

Is condition due to an accidental injury? ☐ Yes ☐ No

If yes, describe the accident. _____

_____

12. Are there secondary conditions contributing to the disability? ☐ Yes ☐ No	If yes, what are they and would the patient be disabled without regards to these secondary conditions?

13. List any test(s) or surgeries performed and submit a copy of the results.

14. Restrictions (What the patient SHOULD NOT do)

15. Limitations (What the patient CANNOT do)

16. 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

17. Is this patient permanently disabled? ☐ Yes ☐ No

18. Is patient considered to be house confined and/or unable to perform 2 out of 5 activities of daily living*? ☐ Yes ☐ No
**Dressing, eating, transferring, toileting and meal preparation.*

List dates (MM/DD/YYYY) of house confinement.* From:_____ To: _____
**House confinement means unable to do normal daily activities.*

19. Dates of Total Disability (MM/DD/YYYY) From:_____ To: _____

Dates of Partial Disability (MM/DD/YYYY) From:_____ To: _____

Patient's expected return to work date (MM/DD/YYYY) _____

20. **List All Office Visit Dates:**		List All Hospitalization Dates:
21. Is patient currently being treated by any other practitioner or therapist? If so, list name and address.		Name and Address of Hospital
22. Signature of Physician or Supplier	Date (MM/DD/YYYY)	Physician's supplier and group name
Telephone Number ( )	Tax ID or SSN	Address
23. Fax Number ( )	Patient Number	

PLEASE SIGN AND RETURN THE AUTHORIZATION (ON REVERSE SIDE) AND CERTIFICATION BELOW TO AVOID DELAY.

CERTIFICATION

Policyholder/Employee's Name_____ Social Security Number _____

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 Warning and State Versions" 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. 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.

_____/_____/_____ _____ _____

Date(MM/DD/YYYY) PATIENT SIGNATURE POLICYHOLDER/EMPLOYEE SIGNATURE

Phone 1.800.325.4368 *Fax 1.800.880.9325*

Authorization for Colonial Life & Accident Insurance Company

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

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms 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 governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life 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. Colonial Life 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 earlier and a copy 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 Colonial Life 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 revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____	_____	***X*** _____	***X*** _____
(Printed name of individual subject to this disclosure)	(Social Security Number)	(Signature)	(Date Signed)

If applicable, I signed on behalf of the insured as _____(indicate relationship). If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____	_____	_____
(Printed name of legal representative)	(Signature of legal representative)	(Date Signed)

Claim Form Addendum: Fraud Warning and State Versions

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.

Resident State	State Version of Fraud Warning
Alaska	A 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.
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.
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.
California	For your protection California 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	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	*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.
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.
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 containing any false, incomplete, or misleading information is guilty of a felony.
Indiana	Any 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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Resident State	State Version of Fraud Warning
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.
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 makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
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 (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.
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.
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.