Disability RMS
Fax (207) 321-3175
Phone 1 - (866) 376-9478

NOTICE OF CLAIM FOR [☐SHORT TERM DISABILITY BENEFITS
☐LONG TERM DISABILITY BENEFITS]

EMPLOYEE'S STATEMENT (TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

NAME OF EMPLOYEE			EMPLOYEE'S SOCIAL SECURITY - -
EMPLOYEE'S ADDRESS	STREET & NO.	CITY	STATE ZIP
TELEPHONE NO. ( ) -		DATE OF BIRTH / /	☐ MALE ☐ FEMALE
☐ RIGHT-HANDED ☐ LEFT-HANDED	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED	IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NUMBER OF DEPENDENT CHILDREN
LIST NAMES AND DATES OF BIRTH OF SPOUSE AND DEPENDENT CHILDREN			
HOW MANY HOURS WERE YOU REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER? ______ hrs.	GROSS SALARY: (During the 12 months just prior to your disability - for this employer only) $ ________________ ☐ HOURLY ☐ WEEKLY ☐ MONTHLY ☐ YEARLY	IF SALARY IS BASED ON LESS THAN 12 MOS. PER YR., INDICATE NUMBER OF MONTHS WORKED PER YEAR ☐ 9 MOS./YR. ☐ 10 MOS./YR. ☐ OTHER ______________________	
NAME OF EMPLOYER		EMPLOYER'S TELEPHONE NO. ( ) -	
EMPLOYER'S ADDRESS	STREET & NO.	CITY	STATE ZIP
YOUR OCCUPATION & TITLE	LIST ESSENTIAL DUTIES OF YOUR JOB AT THE TIME OF DISABILITY		
DATE OF INJURY OR DATE FIRST NOTICED SYMPTOMS OF SICKNESS / /	YOU HAVE BEEN UNABLE TO WORK BECAUSE OF DISABILITY SINCE: / /	YOU RETURNED TO WORK ON A PART-TIME BASIS ON: / /	YOU RETURNED TO WORK ON A FULL-TIME BASIS ON: / /
IS YOUR INJURY OR SICKNESS RELATED TO YOUR OCCUPATION? ☐ YES ☐ NO	IF "YES", EXPLAIN: DID YOU FILE FOR WORKERS' COMPENSATION? ☐ YES ☐ NO		
DESCRIBE HOW AND WHERE INJURY OCCURRED OR DESCRIBE THE ONSET AND NATURE OF YOUR MEDICAL CONDITION INCLUDING SYMPTOMS. IF MORE SPACE IS NEEDED, PLEASE ATTACH SHEET OF PAPER.			
DATE FIRST TREATED / /	TREATED BY: HOSPITAL: ______________________ Name Street Address City State Zip DOCTOR: ______________________ Name Street Address City State Zip		
HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST? ☐YES ☐NO IF "YES", WHEN? ______________________	TREATED BY: HOSPITAL: ______________________ Name Street Address City State Zip DOCTOR: ______________________ Name Street Address City State Zip		

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FOR PREGNANCY DISABILITY ONLY:
Are there any present complications or anticipated difficulties in connection with the following?

(a) Pregnancy ☐ YES ☐ NO Date of last menstrual period: __________ Expected date of delivery __________
(b) Delivery ☐ YES ☐ NO Actual date of delivery: _______________ ☐ Vaginal ☐ C-Section
(c) Post Partum ☐ YES ☐ NO

If "YES" to any of these, please specify in detail: ____

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay	$ ________	________	________	☐	☐
☐	☐	Salary Continuance	$ ________	________	________	☐	☐
☐	☐	Workers' Compensation	$ ________	________	________	☐	☐
☐	☐	Local, State [or National Association or Society] Disability Income Plan	$ ________	________	________	☐	☐
☐	☐	No Fault	$ ________	________	________	☐	☐
☐	☐	Unemployment Compensation disability	$ ________	________	________	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ ________	________	________	☐	☐
☐	☐	Retirement income (normal, early, or disability)	$ ________	________	________	☐	☐
☐	☐	Other STD/LTD Benefits	$ ________	________	________	☐	☐
☐	☐	Other (describe) ________	$ ________	________	________	☐	☐

HAVE YOU APPLIED, OR DO YOU PLAN TO APPLY FOR BENEFITS DESCRIBED ABOVE? ☐ YES ☐ NO
TYPE ____________________________________ DATE APPLICATION FILED ______________
TYPE ____________________________________ DATE APPLICATION FILED ______________

IF YOUR REQUEST FOR BENEFITS IS APPROVED, DO YOU WANT US TO WITHHOLD FEDERAL INCOME TAXES?
☐ YES ☐ NO INDICATE AMOUNT: $ ______________ ($88 MINIMUM PER MONTH)

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND COMPLETE. IF MY ANSWERS ON THIS CLAIM FORM ARE INCORRECT OR UNTRUE, OF IF I REFUSE TO SIGN THE AUTHORIZATION FOR RELEASE OF INFORMATION, [COMPANY NAME] HAS THE RIGHT TO DENY MY CLAIM.

Signature of Employee ____ Date ____________

FRAUD NOTICES

Unless specific state language is provided below, the following general fraud notice applies: *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.*

AR & LA Residents: *Any person who knowingly presents a false or fraudulent claim for payment of 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.*

CA Residents: *For your protection, California law requires the following to appear on the 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.*

CO Residents: *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 policy holder or claim for purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Div. of Ins. within the Department of Regulatory Agencies.*

DC Residents: *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: *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.*

KS, MD, OR & VA Residents: *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.*

NJ Residents: *Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.*

NY Residents: *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 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.*

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DRMS

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

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, 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, to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and Fortis Benefits Insurance Company *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital 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 that the information obtained by use of this authorization will be used by Disability RMS, Fortis Benefits Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Disability RMS or Fortis Benefits Insurance Company solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that 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 that I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or Fortis Benefits Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Disability RMS' and Fortis Benefits Insurance Company's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

***If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).**

****If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.**

*****If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.**

******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 DRMS 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 DRMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.**

Claimant Signature (or Authorized Representative)*___________________________ Date: __________

Description of Personal Representative's Authority [If applicable]:

[*If signed by authorized representative, attach verification of identity]

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NOTICE OF CLAIM FOR [☐SHORT TERM DISABILITY BENEFITS
☐LONG TERM DISABILITY BENEFITS]

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

NAME OF EMPLOYEE

OCCUPATION

IS DISABILITY DUE TO EMPLOYMENT? ☐ YES ☐ NO

DATE EMPLOYED / /

DATE INSURED / /

DATE LAST WORKED / /

REASON FOR STOPPING WORK ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason ____________

DATE RETURNED TO WORK / / ☐ FULL-TIME ☐ PART-TIME

IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK

IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE: / /

DATE EMPLOYMENT TERMINATED / /

DATE DISABILITY INSURANCE TERMINATED / /

REQUIRED NUMBER OF HRS. PER WEEK
_________ hrs.

GROSS SALARY: (During the 12 months just prior to your employee's disability)
$ ____________________
☐ HOURLY ☐ WEEKLY
☐ MONTHLY ☐ YEARLY

IF SALARY IS BASED ON LESS THAN 12 MOS. PER YR., INDICATE NUMBER OF MONTHS WORKED PER YR.
☐ 9 MOS./YR. ☐ 10 MOS./YR.
☐ OTHER ___________

IS EMPLOYEE SUBJECT TO FICA TAX? ☐ YES ☐ NO
IF "YES", IS EMPLOYEE SUBJECT TO ☐ FULL FICA TAX ? ☐ MEDICARE PORTION ONLY?

PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN
(AS OF POLICY YEAR OF DISABILITY)
EMPLOYEE ☐ 100% ☐ OTHER __________%
EMPLOYER ☐ 100% ☐ OTHER __________%
IS EMPLOYEE CONTRIBUTION: ☐ PRE-TAX DEDUCTION? ☐ AFTER-TAX DEDUCTION?

EMPLOYEE ELIGIBLE FOR:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay	$ ________	________	________	☐	☐
☐	☐	Salary Continuance Benefits	$ ________	________	________	☐	☐
☐	☐	Workers' Compensation	$ ________	________	________	☐	☐
☐	☐	Local, State [or National Association or Society] Disability Income Plan	$ ________	________	________	☐	☐
☐	☐	No-fault	$ ________	________	________	☐	☐
☐	☐	Unemployment Compensation disability	$ ________	________	________	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ ________	________	________	☐	☐
☐	☐	Retirement income (normal, early, or disability	$ ________	________	________	☐	☐
☐	☐	Other LTD/STD Benefits	$ ________	________	________	☐	☐
☐	☐	Other (describe) ____________	$ ________	________	________	☐	☐

PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTS TO THIS FORM:
- The employee's Workers' Compensation claim(s) and Approval/Denial Notification
- The employee's prior year's W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability
- The employee's current job description

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

____
NAME OF POLICYHOLDER (COMPANY)

____
PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE

____
MAILING ADDRESS OF POLICYHOLDER (COMPANY)

____
SIGNATURE *DATE*

(________)________ - ______________
TELEPHONE NUMBER

(________)________ - ______________
FAX NUMBER

[PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE]

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ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN

(Please Print or Type)

Name of Patient ______________________________ *FIRST* *MIDDLE* *LAST*		☐ Male ☐ Female	Date of Birth / /
Height ________ Weight ________	Blood Pressure (last visit) Systolic ________/ Diastolic ________	☐ Left-handed ☐ Right-handed	

1. HISTORY:

a. When did symptoms first appear or injury occur? Mo.________ Day ________ Year ________
b. Date patient was unable to work because of impairment Mo.________ Day ________ Year ________
c. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe
____
____
d. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Please explain: ________
e. Was this patient referred to you? ☐ Yes ☐ No If "Yes", by whom and what is their specialty?
____
f. Have you referred this patient to another treating provider? ☐ Yes ☐ No If "Yes", to whom and what is their specialty?
____

2. DIAGNOSIS:

a. Diagnosis impacting function: ____
____
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) ________
____
____
b. Secondary diagnosis impacting function: ____
____
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) ________
____
c. Subjective symptoms: ____
____
d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings): ________
____
____

3. FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with:
(a) Pregnancy ☐ YES ☐ NO Date of last menstrual period: ________ Expected date of delivery: ________
(b) Delivery ☐ YES ☐ NO Actual date of delivery: ________ ☐ Vaginal ☐ C-Section
(c) Post Partum ☐ YES ☐ NO
If "YES" to any of these, please specify in detail: ____
____

4. DATES OF TREATMENT FOR THIS CONDITION:

a. Date of first visit Mo.________ Day ________ Year ________
b. Date of last visit Mo.________ Day ________ Year ________
c. Next office visit Mo.________ Day ________ Year ________
d. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)
____

5. PROGRESS:

(a) Has patient ....☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
(b) Is patient .... ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
If "Hospital Confined", give Name and Address of Hospital ____
____
Confined from ________________ through ________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

6. CARDIAC (if applicable)

Functional Capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
(American Heart Assoc. standards) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

7. CURRENT FUNCTIONAL ABILITY

A. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

___ Hrs. Sedentary Activity 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.

___ Hrs. Light Activity 20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.

___ Hrs. Medium Activity 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.

___ Hrs. Heavy Activity 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

B. Please check appropriate box:

	Occasionally 0% to 33%		Frequency 33% to 66%		Continuously 66% to 100%	
Bending	☐		☐		☐	
Climbing	☐		☐		☐	
Reaching	☐		☐		☐	
Kneeling	☐		☐		☐	
Squatting	☐		☐		☐	
Crawling	☐		☐		☐	
Push/pull	☐	No. of lbs._______	☐	No. of lbs._______	☐	No. of lbs._______
Lifting (lbs.)	☐	No. of lbs._______	☐	No. of lbs._______	☐	No. of lbs._______

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

C. Please list current restrictions (activities which should not be performed) and limitations (activities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific. ____

____

____

____

D. Upper Extremity Function - Please indicate upper extremity functional capabilities:

Simple grasp	☐	Left	☐	Right	Comments ______________________
Pinch	☐	Left	☐	Right	Comments ______________________
Fine manipulation	☐	Left	☐	Right	Comments ______________________
Power grip	☐	Left	☐	Right	Comments ______________________
Repetitive motion	☐	Left	☐	Right	Comments ______________________

8. MENTAL HEALTH ABILITY (if applicable)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

____

____

9. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b. The date you released patient to return to work: ______/_______/______ ☐ Full-time ☐ Reduced hours Number of hours: __________
MO. DAY YEAR

c. Please identify your recommendations for any job modifications that would enable the patient to work.

____

____

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 act, which is a crime and subjects such person to criminal and civil penalties.

ATTENDING PHYSICIAN'S SIGNATURE ____________________________ DATE ________________

PHYSICIAN'S NAME (PLEASE PRINT) ____________________________

DEGREE/SPECIALTY ____________________________

TELEPHONE NUMBER (______)________-_________ FAX NUMBER (_______)_______- __________ TAX ID # ____________________

OFFICE ADDRESS ____________________________
NUMBER/STREET

____
CITY OR TOWN STATE ZIP CODE

[PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE]