

# Disability Claim Filing Instructions

## Have you...

1. Completed the Employee's Statement in full?
2. Had the physician treating you complete the Attending Physician's Statement, and had it returned to you?
3. Had your Employer complete the Employer's Statement, and had it returned to you?
4. Read, signed and dated the Authorization for Release of Information?

**Submit the completed statements to the address below or  
fax to 1-(888) 305-0589.**

**All portions of these forms must be completed  
in order to expedite your claim.**

**If you have any questions when completing this form,  
please call:**

**Toll-Free Phone Number 1-(877) 254-0085**

**Disability RMS  
300 Southborough Drive, Suite 200  
South Portland, ME 04106-6914**

Disability RMS  
 Fax 1-(888) 305-0589  
 Phone 1-(877) 254-0085

**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 / /		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
<input type="checkbox"/> RIGHT-HANDED <input type="checkbox"/> LEFT-HANDED	MARITAL STATUS	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> 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 ANNUAL SALARY: (During the 12 months just prior to your disability - for this employer only) \$ _____		PLEASE INDICATE HOW YOU ARE PAID: <input type="checkbox"/> 9 MOS./YR. <input type="checkbox"/> 10 MOS./YR. <input type="checkbox"/> 12 MOS./YR. <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES", EXPLAIN:  DID YOU FILE FOR WORKERS' COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> 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 / /	IF "HOSPITAL CONFINED", GIVE NAME AND ADDRESS OF HOSPITAL HOSPITAL: _____ Name Street Address City State Zip CONFINED FROM _____ THROUGH _____				
HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No Fault	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other STD/LTD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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

**California Residents:** 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."

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)

(HIPAA COMPLIANT - to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency including the Social Security Administration, 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 (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and Union Security Insurance Company and including, but not limited to, any other mental or psychiatric condition or treatment records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse) *(but excluding psychotherapy notes and Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results)* which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by Disability RMS, Union Security Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim. The information may be re-disclosed to: (a) any medical, investigative, financial or vocational specialist or entity, or any other organization or person, employed by or representing Disability RMS or Union Security Insurance Company, to assist with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Disability RMS or Union Security Insurance Company may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand 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 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 Disability RMS and/or Union Security Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. I understand Union Security Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

Claimant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Claimant Signature (or Authorized Representative): \_\_\_\_\_ Date: \_\_\_\_\_

Description of Personal Representative's Authority (if applicable):  
(If signed by authorized representative, attach verification of identity)

Disability RMS  
Fax 1-(888) 305-0589  
Phone 1-(877) 254-0085

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
DATE EMPLOYED / /	DATE INSURED / /	DATE LAST WORKED / /	REASON FOR STOPPING WORK <input type="checkbox"/> Resigned <input type="checkbox"/> Family Medical Leave of Absence <input type="checkbox"/> Other Reason _____		<input type="checkbox"/> Disability <input type="checkbox"/> Layoff <input type="checkbox"/> Other Leave of Absence	<input type="checkbox"/> Dismissed <input type="checkbox"/> Retired	
DATE RETURNED TO WORK / / <input type="checkbox"/> Full-Time <input type="checkbox"/> 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 HOURS PER WEEK _____ hours	GROSS ANNUAL SALARY (During the 12 months just prior to your employee's disability) \$ _____	PLEASE INDICATE HOW THE EMPLOYEE IS PAID: <input type="checkbox"/> 9 Mos./Yr. <input type="checkbox"/> 10 Mos./Yr. <input type="checkbox"/> 12 Mos./Yr. <input type="checkbox"/> Other _____					
IS EMPLOYEE SUBJECT TO FICA TAX? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", IS EMPLOYEE SUBJECT TO <input type="checkbox"/> Full FICA Tax? <input type="checkbox"/> Medicare Portion Only?							
PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (as of policy year of disability) EMPLOYEE <input type="checkbox"/> 100% <input type="checkbox"/> Other _____% IS EMPLOYEE CONTRIBUTION: <input type="checkbox"/> Pre-Tax Deduction? EMPLOYER <input type="checkbox"/> 100% <input type="checkbox"/> Other _____% <input type="checkbox"/> After-Tax Deduction?							
EMPLOYEE ELIGIBLE FOR:							
YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No Fault	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other STD/LTD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
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							
<b>California Residents:</b> 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". 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

**ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN**  
 (Please Print or Type)

Name of Patient _____ <i>FIRST MIDDLE LAST</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____
Height _____ Weight _____	Blood Pressure (last visit) Systolic _____ / Diastolic _____	<input type="checkbox"/> Left-handed <input type="checkbox"/> Right-handed

**1. HISTORY:**

- a. Is condition due to  Accident?  Sickness?
- b. When did symptoms first appear or injury occur? Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- c. Date patient was unable to work because of impairment Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- d. Has patient ever had same or similar condition?  Yes  No If "Yes", state when and describe  
\_\_\_\_\_
- e. Is condition due to injury or sickness arising out of patient's employment?  Yes  No Please explain:  
\_\_\_\_\_
- f. Was this patient referred to you?  Yes  No If "Yes", by whom and what is their specialty?  
\_\_\_\_\_
- g. 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: \_\_\_\_\_ ICD Code(s) \_\_\_\_\_  
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) \_\_\_\_\_
- b. Secondary diagnosis impacting function: \_\_\_\_\_ ICD Code(s) \_\_\_\_\_  
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 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: \_\_\_\_\_

**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 (American Heart Assoc. standards)       Class 1 (No limitation)       Class 2 (Slight limitation)  
 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%)	Frequently (33% to 66%)	Continuously (66% to 100%)
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/pull	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____
Lifting (lbs.)	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> 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	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Pinch	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Fine manipulation	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Power grip	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Repetitive motion	<input type="checkbox"/> Left	<input type="checkbox"/> 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: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Full-time       Reduced hours    Number of hours: \_\_\_\_\_

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

\_\_\_\_\_

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**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**