

Fax to: Claims 1.866.887.6644

From: _____

Fax Number: _____

Date: _____

Number of pages: _____

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

Disability Claim Form and Instructions



Airline Division



Fax this direction.

What can I do to avoid delays?

Missing information will delay the processing of your claim. Please be sure you:

- Sign** and return the attached Certification on page 2 and Authorization on page 4.
- Complete** the sections that apply to your specific claim.
Please have your **doctor** complete their section(s), if applicable.
- 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 will need to determine if the condition is **pre-existing**. We may have to write your treating physician(s) 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 are faxing your claim, please make a copy of the back pages and fax all pages of the claim together. Please allow **at least two business days** for our automated service center to be updated with information confirming receipt of your fax. You will receive an automated call when your fax has been updated in our system.
- **Please do not mail the original document but keep it for your records.**
- **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. A street address is required.** Your check will be delivered Monday through Friday; however, the time is not guaranteed.

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the individual inquiring on my behalf. Leave blank if you do not want anyone accessing your claim information.

____ sales representative ____ plan administrator ____ spouse, family member or significant other.

____ I want Colonial Life to update me on the status of my claim through electronic messaging at my home phone number indicated on this form. Messages will be left with anyone that answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1.800.325.4368 into my phone.

____ Yes, I want **ALL** payment(s) for this claim sent by overnight delivery. I understand payment(s) under \$100.00 cannot be sent overnight and an \$18.00 fee, which is subject to rate increases by carrier and does not include weekend delivery, will be deducted from my claim payment(s). **We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

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 effect 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 Colonial Life & Accident Insurance Company.

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

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 29209-3195



Fax this direction.

SECTION 1 TO BE COMPLETED BY POLICYOWNER				
1. Policyowner name (First, Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female		If the address given at left has changed since your last claim please mark box with an "x". <input type="checkbox"/>
Patient Name (First, Last)				
2. Address (Street address required for the overnight service option)			Policy Number	
City	State	Zip Code	Social Security Number	Birthdate (MM/DD/YYYY)
Policyowner email address				
3. Claim is for: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness			Home Telephone ()	Work Telephone ()
4. Date and Description of Injury/Sickness			Were you at work at the time of your injury/sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. List Dates (MM/DD/YYYY) unable to work* <i>* Please see instructions for confirmation of Union disability.</i>			If not employed, list dates (MM/DD/YYYY) of house confinement**:	
From:		To:	From:	To:
6. Have you returned to your place of employment? Date returned to Work (MM/DD/YYYY)			** house confinement means unable to do normal daily activities	
7. 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.				

CERTIFICATION

Policyowner/Employee's Name _____ **Social Security #** _____

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. Any person 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.

PLEASE ALSO SIGN AND DATE THE ATTACHED AUTHORIZATION ON PAGE 4.

X ____ / ____ / ____ **X** _____ **X** _____
Date (mm/dd/yyyy) **PATIENT SIGNATURE** **POLICYOWNER/EMPLOYEE SIGNATURE**



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SECTION 2			TO BE COMPLETED BY PHYSICIAN		
8. What is the patient's current primary disabling condition? _____ Symptoms: _____ Objective Findings: _____ If pregnancy, what is the EDC? _____ Is condition due to an accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the accident. _____ _____					
9. Are there secondary conditions contributing to the disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, what are they and would the patient be disabled without regards to these secondary conditions?		
10. List any test(s) or surgeries performed and submit a copy of the results.					
11. Restrictions (What the patient SOULD NOT do)					
12. Limitations (What the patient CANNOT do)					
13. How soon do you expect significant improvement in the patient's medical condition? <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> 5-6 months <input type="checkbox"/> more than 6 months					
14. Is this patient permanently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No					
15. Is patient considered to be house confined and/or unable to perform 2 out of 5 activities of daily living* <input type="checkbox"/> Yes <input type="checkbox"/> 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					
16. List All Office Visit Dates:			List All Hospitalization Dates:		
17. Is patient currently being treated by any other practitioner or therapist? If so, list name and addresses.			Name and Address of Hospital:		
18. Signature of Physician or Supplier		Date (MM/DD/YYYY)		Physician's supplier and group name	
19. Telephone Number ()		Tax ID or SSN		Address	
20. Fax Number ()		Patient Acct. Number			

Authorization for Colonial Life

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.

Printed name of individual	Social Security #	Signature	Date Signed
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If applicable, I signed on behalf of the insured _____ (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
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Claim 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	<i>WARNING:</i> 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.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
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.