Short Term Disability Claim Form

IMPORTANT NOTICE TO EMPLOYEE – PLEASE READ CAREFULLY: You or someone acting on your behalf should complete Section I and then have your employer complete Section II. Have your physician complete Section 3. Submit the form to us at the address or fax number listed below. Your cooperation will facilitate payments promptly when they are due.

Any person who knowingly, and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

Greater Georgia Life
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
[illegible]-232-0113 Fax: 800-850-0017
E-mail: disability@wellpoint.com

Clear Form

Greater Georgia Life Insurance Company

Notice to Customers Regarding Telephone Service Observance
To ensure our customers receive quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

1 Employee name (last, first, M.I.)	2 Gender ☐ Male ☐ Female	3 Birthdate (MM/DD/YYYY)
4 Employee address (street, city, state, ZIP code)	5 E-mail address	
6 Primary phone no.	7 Alternate phone no.	8 Fax no. / 9 Social Security no.
10 Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	11 Employer name	
12 Disability due to ☐ Illness ☐ Injury	13 Date you last worked due to your disability	14 Date you returned to work / 15 If not yet returned, date you expect to return

16 If disability due to injury, what type? ☐ Auto ☐ Worker's Compensation ☐ Home ☐ Other _____

Please provide complete details to accident, date and time (attach a separate sheet if necessary)

I authorize the release to or by Greater Georgia Life any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Greater Georgia Life to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Employee signature **X**	Date (MM/DD/YYYY)

SECTION 2: TO BE COMPLETED BY THE EMPLOYER

17 Group policy no.	18 Date employed (MM/DD/YYYY)	19 Effective date of insurance	20 Occupation/job title
21 Social Security No.	22 Employee no. (if applicable)	23 Employee benefit class ☐ Part-time ☐ Full-time	24 Standard no. of hours worked per week
25 Date employee last worked	26 No. of hours	27 Date employee scheduled to return to work	28 Date employee returned to work
29 Amount of weekly benefits	30 Employee's wage $ _____ per ☐ hour ☐ week ☐ year		31 Employee's compensation ☐ Hourly ☐ Salaried

32 Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No	33 Is claim being made for Worker's Compensation? ☐ Yes ☐ No	34 What percentage of the Short Term Disability premium does the employer pay? _____%

35 If the employee contributes to the premium, contributions are made: ☐ Pre-Tax ☐ Post-Tax	36 Comments

37 Group name	38 Branch or division address	29 Phone no.

Signature of employer representative **X**	Printed name of local chairman	Title	Date (MM/DD/YYYY)

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Save and Print Form

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Disability Claims Service Center
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Atlanta, GA 30348-5426
Phone: 800-232-0113 Fax: 800-850-0017
E-mail: disability@wellpoint.com

Greater Georgia Life
Insurance Company

SECTION 3: TO BE COMPLETED BY PHYSICIAN

Note to Physician: Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

1 Patient's name (last, first, M.I.)			2 Birthdate (MM/DD/YYYY)
3 Current diagnosis		4 ICD-9 code/DSM IV	
5 Subjective complaints		6 Objective findings	
7a Has patient ever had same or similar condition? ☐ Yes ☐ No	7b If yes, please specify dates of treatment	8 Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown If yes, please explain: _____	
9a Is disability due to pregnancy? ☐ Yes ☐ No	9b If yes, LMP (MM/DD/YYYY)	9c EDC (MM/DD/YYYY)	9d Type of delivery ☐ Vaginal ☐ C-section
10a Was patient hospitalized? ☐ Yes ☐ No	10b If yes, please provide date of confinement	10c Name of hospital/facility	
11a Nature of surgical procedure, if any. (Describe in full.)			11b Date performed (MM/DD/YYYY)
12 Date patient first unable to work	13 Date of first visit	14 Date of last visit	15 Patient's present condition
16 Frequency of visits ☐ Weekly ☐ Monthly ☐ Other: _____		17 Treatment plan	
18 Functional impairments		19 Current medications and dosages	
20a Patient released to return to work? ☐ Yes ☐ No If yes: ☐ Full-time, no restrictions ☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.)		20b Date able to return to full duty	20c Date able to return to light duty
21 Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No		22 Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No	
23 Physician printed name			24 Physician specialty
25a Physician street address		25b City	25c State / 25d ZIP code
26 Physician phone no.	27 Physician fax no.	28 Physician e-mail address	

Signature of physician **X**	Date (MM/DD/YYYY)

The laws of some states require us to provide you with the following information:

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.

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.

Arkansas, Louisiana, and 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.

California: For your protection California 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 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.

Delaware and Idaho: 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.

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.

Florida: 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 of the third degree.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing 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.

Maine, Tennessee, Virginia, and 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 may include imprisonment, fines or denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps to commit a fraud against an insurer is guilty of a crime.

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 N.H. Rev. Stat. Ann. §638:20.

New Jersey: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: A 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 materials 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 violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and 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.

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.

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.