Administrator's Office
PO BOX 25326
Overland Park, Kansas 66225-5326
1-800-237-4463

ACCIDENT/SICKNESS DISABILITY CLAIM FORM
INSURED'S PORTION

PART 1

Insured Name: ______________________ Date of Birth: ______________________
Address: ______________________ Policy Number: ______________________

Is this claim for disability? __________ Is disability due to accident or sickness? __________
If claim is for disability due to accident, please furnish date: __________ and time: __________ AM/PM and
Location and type of incident: ______________________
Brief description of accident: ______________________
Were you disabled before the accident? __________ From: __________ To: __________
If automobile accident, were you the driver? __________ Passenger? __________
What injuries did you sustain as a result of the accident? ______________________
Please enclose a copy of the police report if an automobile accident.
No longer disabled as of: __________
If disability is sickness related, symptoms first occurred on: __________
What is diagnosis? __________ Describe: __________
____
Have you ever had a similar condition before? __________ If yes, state when and describe: __________
____
List any chronic sickness or disease and onset date: ______________________
Are you currently receiving Social Security Disability Benefits? ______ If yes, when did you first begin to receive SSI benefits?
______________________ Have you applied for Workers Compensation Benefits? __________
If yes, what date did you start receiving Workers Comp. benefits? From: __________ To: __________
Referring Physician (Name & Address): ______________________
Were you hospitalized? __________ If yes, From: __________ To: __________
Name and address of hospital: ______________________
If you are disabled, please furnish the following information and answer the following questions:
Employer Name: ______________________
Employer Address: ______________________
Employer Phone Number: ______________________
Insurance coverage you carry: ______________________
____
Totally disabled? From: __________ To: __________
Partially disabled? From: __________ To: __________
If retired or employed less than 30 hours per week, which activities of daily living are you unable to perform? __________
____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, the MIB, Inc., or other organization, institute or person, that has any records or knowledge of me or my health to give to the Company's or Our authorized representative, any such information. A photographic copy of this authorization shall be valid as the original. I hereby certify that the foregoing information is correct and complete.

Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 2 and 3 for notice specific to your state.

Date: __________ Signature: ______________________ Print Name: ______________________

Important Claim Notice - CLAIM FRAUD WARNING

All States Except As Indicated Below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 may be a crime and may subject such person to criminal and civil penalties.

Alabama, Arkansas, District Of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files 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.

California: 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.

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, Idaho, Indiana, 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.

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

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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a 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.

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 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 violation.

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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.

If you are filing a claim for disability, please have your employer and physician complete PARTS 2 & 4

PART 2 ATTENDING PHYSICIAN'S STATEMENT – disability must be verified by a licensed medical practitioner, not a DC.

Patient's Name: ______________________ Age: __________

1. Diagnosis: ______________________ ICD9 Code: __________
2. If condition is due to pregnancy, what is expected delivery date? __________
3. When did symptoms first appear or accident happen? __________
4. When did patient first consult you for this condition? __________
5. Has patient ever had same or similar condition? ______ If "yes", state when and describe: __________
6. Describe any other diseases or infirmity affecting present condition. __________
7. Nature of surgical or obstetrical procedure, if any (describe fully). __________
8. Is patient unable to perform job duties? ______ If yes, From: __________ To: __________

9a. What specific job duties is patient unable to perform? __________

9b. Specific RESTRICTIONS? (What the patient should not do and why.) __________
Please quantify in hours, weight, etc. __________

9c. Specific LIMITATIONS? (What the patient cannot do and why.) __________

10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? __________

11. Date patient last examined by you: __________ Frequency of visits, Weekly: ____ Monthly: ____ Other: ____

12. Is patient, Ambulatory: ____ Bed Confined: ____ House Confined: __ Other: ____

13. If patient is hospitalized, give name and address of hospital. __________

14a. Date admitted: __________ Date discharged: __________

14b. When do you expect patient to resume partial duties? __________ Full duties? __________

14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? __________

15. Is condition due to injury or sickness arising out of patient's employment? __________

If "yes", explain: __________
Name and address of referring physician, if any. __________

16. Have you completed paperwork for any other insurance company or Social Security Disability? __________

Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to pages 2 and 3 for notice specific to your state.

PHYSICIAN VERIFICATION

Signed: ______________________ Date: __________ Phone: ( )
Print Name: ______________________ Designations: __________ Fax: ( )
Street Address: ______________________
City/Town: __________ State/Province: __________ Zip Code: __________

If you are claiming CONTINUING DISABILITY, please have your employer and physician complete PARTS 3 & 4

PART 3 ATTENDING PHYSICIAN'S STATEMENT FOR CONTINUING DISABILITY

FIRST CLAIM FOR DISABILITY due to Accident or to Sickness: DATE: ______________

1. Is this claim for continuation of a previous disability? ______
2. Diagnosis: ______________________ Diagnosis Code: ______________
3. Describe any other diseases or infirmity affecting present condition. ______________________
4. Date of initial disability due to this diagnosis: ____________
5. Is patient unable to perform job duties? _____ If yes, may return to work part-time: __________ Full-time: __________
6. If retired or unemployed, which activities of daily living (ADL's) is patient unable to perform? ______________________
7. Date patient last examined by you: ____________ Frequency of visits, Weekly: _____ Monthly: _____ Other: _____
8. Is patient: Ambulatory: ____ Bed Confined: ____ House Confined: _____ Other: ____

9a. If patient is hospitalized, give name and address of hospital: ______________________

9b. Date admitted: ______________ Date discharged: ______________

10. When do you expect patient to resume partial duties? ____________ Full duties? ______________

11. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? ______________

12. Is condition due to injury or sickness arising out of patient's employment? ________
If "yes", explain: ______________________

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PHYSICIAN VERIFICATION

Signed: ______________________ Date: ____________ Phone: ( ) ______________

Print Name: ______________________ Designations: ________ Fax: ( ) ______________

Street Address: ______________________

City/Town: ______________ State/Province: ______________ Zip Code: ______________

Statement of Employer

Remember it may be a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing.

1. Employee's Name: ______________________ Date of Hire: ______________

2. Last Date Worked due to disability: ______________________ Date Returned to Work: ______________

3. Reason for stopping work: ____

____

____

4. When recovered, will he/she resume work? ________ If not, why? ______________

5. Job duties at time of disability: ____

____

6. Work schedule at time of disability: ________ Days per week ________ Hours per day

7. Does employee have option for "light duty" work: ______________________

8. At the time of disability, what was the monthly salary $: ________ Monthly salary at time of disability $ ________

9. Is disability a result of a work injury: ________ Has a claim been filed: ________

10. Is employee receiving workers' compensation: Yes ____ No ____ Amount $ ________

11. Does employee qualify for Short Term or Long Term Disability through employer: ________
If yes, Amount $ ________ for ____ weeks

Name and Address of employer's Insurance Company: ______________________

____

____

Employer: ____

Address: ____

____

Authorized Signature: ______________________ Title: ______________________

Print Name: ____

Telephone Number: ______________________ Date: ______________________