



# Continuing Disability Claim Form



Fax this direction.

Fax to: Claims 1.866.887.6644

From: \_\_\_\_\_

Number of pages: \_\_\_\_\_

Mail to:

P.O. BOX 100195

Columbia SC 29210

Questions? Call 1.800.325.4368 • 24 Hours A Day / 7 Days a Week

(Do Not Use this Form if this is the first time you are filing for this injury or sickness)

If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

Section 1 TO BE COMPLETED BY POLICY OWNER		
Claimant name _____ ___ Male ___ Female	Birth Date _____	Claimant Social Security Number _____
Mailing Address (Street or PO Box) _____		Apartment/Unit/Lot Number _____
(City) _____	(State) _____	(Zip) _____
Policy owner e-mail address _____		Work telephone _____
Claim is for: ___ Accident ___ Sickness	Condition that keeps you from working _____	
Date the accident occurred (not when it was treated) _____	Description of accident _____	
Were you at work at the time of your accident or sickness? ___ Yes ___ No	Dates unable to work: From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)	
Have you been unable to perform any activities of daily living? ___ Yes ___ No If yes, please list the dates you were unable to perform the activities: From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)		
Check the activities that you are unable to perform: ___ dressing ___ eating ___ meal preparation ___ toileting ___ continence ___ bathing ___ transferring		
If not employed, list dates of house confinement: From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)		House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.
Date you returned to work: Full-time _____ Part-time _____/Hours worked per week _____ (MM/DD/YYYY) (MM/DD/YYYY)		
Section 2 TO BE COMPLETED BY EMPLOYER(S)		
Dates employee unable to work (Full-time) From _____ AM/PM To _____ AM/PM (MM/DD/YYYY) (MM/DD/YYYY)	Was employee at work when the accident or sickness occurred? ___ Yes ___ No	
Date returned to work: Full-time _____ AM/PM Part-time _____ AM/PM/Hours per week _____ (MM/DD/YYYY) (MM/DD/YYYY)	Employee job title _____	
Expected return to work (MM/DD/YYYY)	Who should we contact for updates on return to work status? Name/Phone/Email _____	
FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.		
Signed by _____		Title _____
Print name _____		Date _____
Telephone Number( ) _____		Fax Number( ) _____
Email Address: _____		

### Claim Fraud Statements

For your protection, the laws of several states, including **Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma**, and others require the following statement to appear on this claim form. **Fraud Warning** : 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.

**Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arizona Residents** : 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, Rhode Island, Texas and West Virginia Residents** : For your protection, California, Rhode Island, Texas and West Virginia 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 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 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**: 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 Residents** : 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.

**Kentucky** : For your protection, Kentucky law requires the following to appear on this form: 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 Residents** : 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 Residents** : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Jersey and New Mexico** : Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York 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 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.

**Pennsylvania 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 insurance act, which is a crime and subjects such person to criminal and civil penalties

**Oregon Residents** : Any person who, knowingly and 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 that is relied upon by the insurer and is material to the content of the policy and to the risk assumed by the insurer, may be prosecuted for insurance fraud. There is no time limit on contestability in the event of fraud on the part of the insured.

**Puerto Rico Residents** : 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

<b>Section 3 TO BE COMPLETED BY PHYSICIAN</b>		
Patient's name		Patient's DOB
What primary condition prevents the patient from working?		
Symptoms:		Objective Findings:
Date first treated for this condition _____ (MM/DD/YYYY)		If pregnancy, what is EDC? _____ (MM/DD/YYYY)
Is condition due to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date and description of accident.		
Are any secondary conditions preventing the patient from working? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what are these secondary conditions?
When did symptoms first appear? _____ (MM/DD/YYYY)	Date of new patient consultation _____ (MM/DD/YYYY)	Date of patient's last visit. _____ (MM/DD/YYYY)
List any test(s) performed and submit a copy of the results.		List any surgeries performed with the date and procedure code.(CPT) (Attach a copy of the operative report)
Restrictions (What the patient SHOULD NOT DO)		
Limitations (What the patient CANNOT DO)		
How soon do you expect significant improvement in the patient's medical condition? ____ 1-2 months ____ 3-4 months ____ 5-6 months ____ more than 6 months		Expected return to work _____ (MM/DD/YYYY)
Dates unable to work (full-time): From: _____ To: _____ (MM/DD/YYYY) (MM/DD/YYYY)	Dates unable to work (part-time): From: _____ To: _____ (MM/DD/YYYY) (MM/DD/YYYY)	Actual date released to return to work _____ (MM/DD/YYYY)
Does this patient have permanent restrictions/limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not employed, list dates of house confinement: From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)	House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.
Please check the activities of daily living that the patient is unable to perform: <input type="checkbox"/> dressing <input type="checkbox"/> eating <input type="checkbox"/> meal preparation <input type="checkbox"/> toileting <input type="checkbox"/> continence <input type="checkbox"/> bathing <input type="checkbox"/> transferring		
Date(s) of office visit (Last 3 Months)		How often do you see the patient?
Have you referred patient for other types of consultations? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and address of Specialist
Dates of Hospitalization (Last 3 months)		Name and Address of Hospital
<b>FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.</b>		
Signature of Physician		Date _____ (MM/DD/YYYY)
Physician's Specialty		
Telephone number ( )	Fax Number ( )	Tax ID or SSN
Physician/Group Name		Patient Account Number
Mailing Address		Do you accept Medical Records request by Fax? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have authorization on file to release information to Colonial Life? <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide the following information for referring doctor. Name:		Phone number
Address		Fax
Policy Owner		Policy Owner Social Security Number

- Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them. This is called an assignment. If you wish to assign your benefits, please send a signed written request.
- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

**CERTIFICATION**

**Policy owner'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. I acknowledge that I received the Claim Fraud Statements on page 2 of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. **Fraud Warning: 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.**

X \_\_\_\_\_  
Claimant's Signature

X \_\_\_\_\_  
Policy owner's Signature

X \_\_\_\_\_  
Date (MM/DD/YYYY)



Fax this direction.