

Short Term Disability Claim Application

P.O. Box 2272
Seattle, WA 98111-2272
Tel: (425) 918-4575
Fax: (425) 918-4485
Toll Free: 1-800-258-0394



To file an application for Short Term Disability benefits, please follow the instructions below to avoid unnecessary delays.

Any cost for completion of this form will be at the insured's expense.

The application for benefits requests information that is necessary to the speedy and accurate administration of your claim. If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (not applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization and Disclosures

You (the employee) must fully complete the "Authorization," page 2. This will allow us to secure additional information (if necessary) to make a decision on your claim. We cannot process the claim if this is not completed.

Section 2: Employee's Statement

Fully complete the section "To Be Completed by Employee," page 3.

Section 3: Employer's Statement

Have the employer fully complete the section "To Be Completed by Employer," page 4.

Section 4: Physician's Statement

Have the attending physician complete the section "To Be Completed by Physician," page 5. Please complete the top line with your name, date of birth and social security number before giving the form to your physician.

When ALL sections of this form have been completed, please send it to us at the above address by mail or fax.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Section 1: To Be Completed by Employee

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

Authorization for Release of Information

Persons or Institutions: This authorizes you to give LifeWise Assurance Company, its reinsurers, representatives, or persons performing business or legal services on behalf of LifeWise Assurance Company any information, data or records you have regarding my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use, and any medical condition I may now have or have had), and any information, data or records regarding my Social Security, FICA earnings history, Worker’s Compensation, state disability, pension, credit, financial, earnings and employment history needed to evaluate my claim for disability benefits.

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 LifeWise Assurance Company to assist with this purpose. This authorization is valid during the pendency of my claim. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Group Name Group Policy Number

Name (please print) Address

Signature Date

Please read the following notice that we are required by law to give to you. Please make copy for your file.

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this claim form may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecuting under Federal Mail Fraud, Federal Wire Fraud, and/or Federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

For your protection, California law requires the following to appear on this form:

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

In addition, submission of false information in connection with this claim form may also constitute a crime under federal laws. LifeWise Assurance Company will pursue any appropriate legal remedies in the event of insurance fraud, including prosecution under Federal Mail Fraud, Federal Wire Fraud, and/or the Federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

Note to Pennsylvania Claimants:

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.

Short Term Disability Employer's Statement

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Section 3: To Be Completed by Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1 Employee's Name		2 Social Security No.	
Street/Box/Apt.		3 Date of Birth / /	
City, State, ZIP		4 Regularly Scheduled Hours Per Week	

5 Date of Hire / /	6 STD Insurance Effective Date / /	7 Occupation
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8 Policy No.	9 Policy Division No.	10 Policy Class
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11 Employee's Work Schedule Full Time Part Time Exempt Non-Exempt Seasonal

12 Check Regular Workdays Sun Mon Tues Wed Thurs Fri Sat Varies

13 If not at work when disability began, (check status and provide date) <input type="checkbox"/> Terminated <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Laid Off <input type="checkbox"/> Sick Leave _____ <input type="checkbox"/> Vacation <input type="checkbox"/> Resigned Date / /	14 How was employee paid? (check appropriate box) <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Salary and Bonus <input type="checkbox"/> Weekly <input type="checkbox"/> Commissions <input type="checkbox"/> Commissions Only <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Salaried <input type="checkbox"/> Salary and Commissions
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15 Salary Prior to Date Last Worked Base Weekly Wages \$ _____ W-2 Earnings \$ _____ Overtime \$ _____ Commissions \$ _____ Bonus \$ _____	16 Date last Salary Increase / / 17 Employee Work Schedule at Time Last Worked _____ Days per week _____ Hours Per Week \$ _____ Hourly Wage	18 Date Last Worked / / 19 Hours Worked That Day
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20 How long has employee been in this job? _____

21 Has Employee Returned to Work? Yes No
 If yes, Date / / Full Time Part Time

22 Date Paid Through / / for Salary continuation Vacation Accrued Sick Pay

23 Does employee contribute toward the STD premium? Yes No If yes, Pre-Tax Post-Tax
 _____% paid by employer _____% paid by employee

24 Should Social Security and/or Medicare taxes be withheld? Social Security? Yes No Medicare? Yes No

25 Is this group plan subject to ERISA? Yes No

26 Employee is Eligible for	Yes No		If yes, Weekly or Monthly Amount	Wk Mo		Provider Name/Address	Date Benefits Begin	(Use four digits for year) Through
Salary Continuation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Retirement Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Auto No Fault	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Social Security	<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"/>			
Has Workers Comp Claim been filed?	<input type="checkbox"/>	<input type="checkbox"/>	If Workers Compensation has been denied, submit copy of denial with this claim.					

27 Does your company have a rehire or return to work policy for disabled employees? Yes No
 What is the name of the person we should contact if we identify a return to work option?

28 Name/Address of the employee's medical insurance carrier or HMO (provide policy or ID No.)

29 Employer Name	Phone No. ()	Fax No. ()
Address	City	State ZIP
Name of person completing this form (Please Print)	Title	E-mail
Signature (The above statements are true and complete to the best of my knowledge) X		Date / /

**Short Term Disability
Physician's Statement**

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Section 4: To Be Completed by Physician

**If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.
Any cost for completion of this form will be at the insured's expense.**

Patient Name		Date of Birth	Social Security No.
Height	Weight	Blood Pressure (last visit)	
1 Patient is/was unable to work due to: (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy			
2 Diagnosis (included complications and ICD 9)			

Complete this section for Normal Pregnancy, then go to item 29

If disabled date is greater than two weeks before EDC complete lines 18, 19, 20, 22, 23 & 24.

3 What was LMP date? / /	4 What is the <input type="checkbox"/> expected or <input type="checkbox"/> actual date of delivery? / /	5 Date you advised patient to stop working / /
6 Expected length of postpartum recovery	7 <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> planned <input type="checkbox"/> Cesarean delivery <input type="checkbox"/> actual	8 Date First treated / /
		9 Date Last Treated / /

Complete the following items for all conditions except Normal Pregnancy

10 When did symptoms first appear or accident happen	11 Date you advised patient to stop working / /	12 Is condition due to injury or illness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
13 Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state when and describe	14 Is this an illness? <input type="checkbox"/> Injury? <input type="checkbox"/> Work related? <input type="checkbox"/>	
15 Date of First Visit / /	16 Date of Last Visit / /	17 Frequency of Visits
18 Objective Findings (X-rays, EKGs, lab data and clinical findings)		19 Subjective Symptoms

20 Nature of Treatment (type of surgery, name of medications, etc.)

21 Names and addresses of other physicians

22 Has patient been hospitalized? If Yes, give name and address
 Yes No
From / / to / /

23 Restrictions (what the patient SHOULD NOT do)	24 Limitations (what the patient CAN NOT do)
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25 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis

I	III	V
II	IV	

26 If this is a cardiac condition, what is the functional capacity? (American Heart Association)

<input type="checkbox"/> Class 1-No Limitation	<input type="checkbox"/> Class 3-Marked Limitation
<input type="checkbox"/> Class 2-Slight Limitation	<input type="checkbox"/> Class 4-Complete Limitation

27 Has maximum medical improvement been achieved? Yes No If no, when do you expect a fundamental change?
 1-2 weeks 3-4 weeks 5-6 weeks more than 6 weeks

28 When is patient released to return to work? / /

<input type="checkbox"/> Part time <input type="checkbox"/> Full time
<input type="checkbox"/> With no restrictions <input type="checkbox"/> With restrictions (see box 21 & 22)

29 Physician name (Please Print)	Degree	E-mail	
Specialty	Phone No. ()	Fax No. ()	
Address	City	State	ZIP
Signature (No Stamp) X	Tax ID NO.	Date / /	

