Allstate HEALTH SOLUTIONS

Disability Claim Form and Instructions

If you have any questions about completing this form, call us at (855) 323-4750
7:00 a.m. to 6:00 p.m. CST.

INSTRUCTIONS FOR FILING CLAIM FOR DISABILITY

To be completed by the insured

Include your policy number. To obtain your policy number call (855) 323-4750.

Sections 1, 2 and 3 should be completed and signed by claimant.

Include a copy of your W-2 form from the year the policy was issued.

To be completed by the employer

Section 4 should be completed and signed by your employer. If you are self-employed, also send us a copy of your current business license and your most recent quarterly tax records. Additional information may be required.

To be completed by the physician

Section 5 should be completed and signed by your physician.

You may **fax** your claim to us at **317-284-7281**.

You may **mail** your claim to: **Allstate Health Solutions**
P.O. Box 3252
Milwaukee, WI 53201-3252

SECTION 1: CLAIMANT (Disabled Party)			**POLICYHOLDER (Primary Insured)**		
Last First MI			Last First MI		
☐ Male ☐ Female	☐ Right-handed ☐ Left-handed	Birth Date _____/_____/_____	Address		Birth Date _____/_____/_____
Relationship to Policyowner: ☐ Spouse ☐ Widowed ☐ Divorced ☐ Self			City State ZIP		☐ Check if new address
Social Sec. No.	Phone No.		**Policy No.**	Social Sec. No.	Phone No.

SECTION 2: Policyowner's Statement *(To avoid delay, all questions must be answered)*

Name of Employer		Employer's Phone Number	
Employer's Address	City	State	ZIP
Your Occupation & Title	List essential duties of your job at the time of disability		
How many hours were you regularly working per week prior to the disability with your present employer? _____ hrs.		Gross annual salary: (During the 12 months just prior to your disability – for this employer only) $_____	
Date of injury or date first noticed symptoms of sickness: _____/_____/_____	You have been unable to work because of disability since: _____/_____/_____	You returned to work on a part-time basis on: _____/_____/_____	You returned to work on a full-time basis on: _____/_____/_____
Is your injury or sickness related to your occupation? ☐ Yes ☐ No	If "Yes," explain:		Did you file for workers' compensation? ☐ Yes ☐ No
If auto accident, was the claimant: ☐ Driver ☐ Passenger **Include a copy of the incident or police report if applicable.**	Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms. If more space is needed, please attach sheet of paper or additional documentation.		
Date first treated: _____/_____/_____	If "Hospital Confined," give name and address of hospital Hospital: _____ (Name, Street Address, City, State, ZIP) Confined from _____/_____/_____ Through _____/_____/_____		
Have you ever had the same or similar condition in the past? ☐ Yes ☐ No	Treated by: Hospital: _____ (Name, Street Address, City, State, ZIP) Doctor: _____ (Name, Street Address, City, State, ZIP)		

For Pregnancy Disability Only:
Are there any present complications or anticipated difficulties in connection with the following?

a. Pregnancy ☐ Yes ☐ No Date of last menstrual period: _____/_____/_____ Expected date of delivery: _____/_____/_____

b. Delivery ☐ Yes ☐ No Actual Date of Delivery: _____/_____/_____ ☐ Vaginal ☐ C-Section

c. Post Partum ☐ Yes ☐ No

If "Yes" to any of these, please specify in detail: _____

_____

_____ _____
Signature of Claimant Date

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.

Include a copy of your W-2 form from the year the policy was issued.

Claimant name:
Claimant date of birth:
Provider/Facility (completed by Insurer/Requester at time of request):

Authorization for the Release and Disclosure of Confidential Medical Information

The records and information obtained pursuant to this Authorization will be disclosed to National Health Insurance Company, Integon National Insurance Company, and/or Integon Indemnity Corporation (collectively "Allstate Health Solutions"), any consumer reporting agency authorized by Allstate Health Solutions, its legal representative(s), its third party administrator(s) (including Key Benefit Administrators), or any medical records retrieval service Allstate Health Solutions may engage, including, but not limited to, American Retrieval Company, and its agents.

I, or my legal representative, do hereby authorize any and all of my medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records' custodians, or any other health care provider to release any and all records and information, including diagnosis, testing, treatment and prognosis of my physical or mental condition, within their possession, custody or control regarding me in accordance with this Authorization. Such records and information to be released may include, but not to be limited to the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, Human Immunodeficiency Virus (HIV) testing and treatment, Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Disease (STD) testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's. I understand that the purpose of this disclosure is to evaluate the eligibility of benefits or my claims for payment with respect to my insurance coverage with Allstate Health Solutions.

This authorization will remain in effect for a maximum of one year from the date of my signature below.

I understand that I may revoke this authorization at any time by sending a written notification via U.S. Mail to Attention: Privacy Department, P.O. Box 2070, Milwaukee, WI 53201-2070 or fax to 317-284-7281. I understand that a revocation of this authorization is not effective if Allstate Health Solutions has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the coverage itself. This revocation will be effective for future uses and disclosures only and will not apply to information that has already been used or disclosed in reliance on this authorization. Once health information about me has been disclosed by Allstate Health Solutions to a third party, the health information may be subject to redisclosure by the recipient and no longer be protected by federal privacy laws. If I choose not to sign this authorization or if I later revoke it, I understand that Allstate Health Solutions may not be able to process my application for coverage; if coverage has been issued, Allstate Health Solutions may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services. Your provider may require you to complete an additional authorization form. If asked to complete this authorization, your prompt response will help expedite the process.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

Signature of claimant/legal guardian	Relationship of legal guardian
Print name of claimant/legal guardian	Date signed (mm/dd/yyyy)

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

Signature of legal representative	Relationship
Print name of legal representative	Date signed (mm/dd/yyyy)

SECTION 4: Employer's or Administrator's Statement *(If self-employed, please fill out all applicable sections)*

Name of Employee	Occupation	Is disability due to employment? ☐ Yes ☐ No

Date Employed	Date Last Worked	Reason for Stopping Work
_____/_____/_____	_____/_____/_____	☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason _____

Date Returned to Work	If returning part-time, amount of pay Employee is receiving:	If Employee has not returned to work, estimated return to work date:	Date Employment Terminated:	Required number of hrs. per week:
_____/_____/_____ ☐ Full-Time ☐ Part-Time	$_____ per ☐ Hour ☐ Week *(Select one)*	_____/_____/_____	____/____/____	_____hrs.

Gross Annual Salary: (During the 12 months just prior to your employee's disability)	Please attach a copy of the following documents to this form: ☐ The Employee's prior year's W-2 form ☐ The Employee's current job description OR list the current job duties/description: _____
$ _____	_____

Is the Employee receiving any compensation while on disability (such as sick leave, vacation, paid-time-off or salary continuation)? _____

_____

_____

What portion of the Employee's income is being compensated?

Pretax $ _____ representing _____ % of employee's predisability income.

How long will the compensation last while the employee is out on disability? _____

_____

_____

_____ Name of Employer	_____ Print Name & Title of Official Representative
_____ Mailing Address of Employer	_____ Signature Date
_____ Phone No.	_____ Fax No.

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.

PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE

SECTION 5: SECTION 5: Attending Physician's Statement *(Must be filled-in completely by a Physician - Please Print or Type)*

First Name of Patient	MI	Last	☐ Male ☐ Female	Birth Date _____/_____/_____
Height_____	Weight _____	Blood Pressure (last visit) Systolic _____/Diastolic _____	☐ Left-handed ☐ Right-handed	

1. HISTORY:

a. Is condition due to ☐ Accident? ☐ Sickness? ☐ Pregnancy?

b. When did symptoms first appear or injury occur? Mo. _____ Day _____ Year _____

c. Date patient was unable to work because of impairment Mo. _____ Day _____ Year _____

d. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe

_____

_____

e. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Please explain:

_____

f. Was this patient referred to you? ☐ Yes ☐ No If "Yes," by whom and what is their specialty?

_____

g. Have you referred this patient to another treating provider? ☐ Yes ☐ No If "Yes," to whom and what is their specialty?

_____

2. DIAGNOSIS:

a. Diagnosis impacting function: _____

ICD-9 Code(s) _____

Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

_____

_____

b. Secondary diagnosis impacting function: _____

_____

Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

_____

_____

c. Subjective symptoms: _____

_____

d. Objective Findings (including current x-rays, EKGs, laboratory data and any clinical findings) _____

_____

_____

3. FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with:

a. Pregnancy ☐ Yes ☐ No Date of last menstrual period: _____/_____/_____ Expected date of delivery: _____/_____/_____

b. Delivery ☐ Yes ☐ No Actual Date of Delivery: _____/_____/_____ ☐ Vaginal ☐ C-Section

c. Post Partum ☐ Yes ☐ No

If "Yes" to any of these, please specify in detail: _____

_____

4. DATES OF TREATMENT FOR THIS CONDITION:

a. Date of first visit Mo. _____ Day _____ Year_____

b. Date of last visit Mo. _____ Day _____ Year_____

c. Next office visit Mo. _____ Day _____ Year_____

d. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____

5. PROGRESS:

a. Has patient: ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

b. Is patient: ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

If "Hospital Confined," give Name and Address of Hospital _____

_____

Confined from: _____/_____/_____ through: _____/_____/_____

6. CARDIAC (if applicable):

Functional Capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)

(American Heart Association standards) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

7. CURRENT FUNCTIONAL ABILITY:

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours)

___ Hrs. Sedentary Activity — 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.

___ Hrs. Light Activity — 20 lbs. maximum lifting, carrying 10 lb. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.

___ Hrs. Medium Activity — 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.

___ Hrs. Heavy Activity — 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

b. Please check appropriate box:

	Occasionally 0% to 33%	Frequently 33% to 66%	Continuously 66% to 100%
Bending	☐	☐	☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push/pull	☐ No. of lbs. _____	☐ No. of lbs. _____	☐ No. of lbs. _____
Lifting (lbs.)	☐ No. of lbs. _____	☐ No. of lbs. _____	☐ No. of lbs. _____

What is this assessment base on? ☐ Observed activity ☐ Measured capacity ☐ Physical therapy report

c. Which Activities of Daily Living (ADLs) is patient unable to perform? (Check all that apply)

☐ Continence ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating

d. Please list current restrictions (activities which should not be performed) and limitations (activivities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific. _____

_____

_____

_____

e. Upper Extremity Function – Please indicate upper extremity functional capabilities:

Simple grasp	☐ Left	☐ Right	Comments _____
Pinch	☐ Left	☐ Right	Comments _____
Fine manipulation	☐ Left	☐ Right	Comments _____
Power grip	☐ Left	☐ Right	Comments _____
Repetitive motion	☐ Left	☐ Right	Comments _____

8. MENTAL HEALTH ABILITY (if applicable):

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

_____

_____

9. RETURN TO WORK PLAN:

a. Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b. The date you released patient to return to work: _____/_____/_____ (MO./DAY/YEAR) ☐ Full-time ☐ Reduced hours Number of hours: _____

c. Please identify your recommendations for any job modifications that would enable the patient to work. _____

_____

Attending Physician's Signature _____ Date _____

Physician's Name (Please print) _____

Degree/Specialty _____

Phone Number (_____)_____-_____ Fax Number (_____)_____-_____ Tax ID# _____

Office Address _____
Address

_____
City or Town State ZIP

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PLEASE RETURN COMPLETED FORM TO YOUR PATIENT

FRAUD WARNING NOTICES:

For states not listed below: 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 subject such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents 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: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas & District of Columbia: Warning - 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.

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 : Warning - 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.

Kentucky: A 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: 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.

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.

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.

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.