

# Combined Insurance Company of America

Claim Department • P.O. Box 6700 • Scranton, PA 18505-0700 • Telephone 1-800-225-4500 • Fax 312-351-6930

## Supplemental Disability Claim Form

CLAIMANT STATEMENT - PLEASE COMPLETE AND RETURN					
FIRST NAME		LAST NAME			M.I.
CLAIM NUMBER		POLICY/CERTIFICATE NUMBER(S)			
PRIMARY PHONE					
MAILING ADDRESS					
CITY		STATE	ZIP		
E-MAIL ADDRESS					
PLEASE DESCRIBE ANY COMPLICATIONS OF INJURY OR ILLNESS SINCE LAST REPORT.					
LIST MEDICAL TREATMENTS RECEIVED SINCE LAST REPORT					
DOCTOR'S NAME		TREATMENT DATES:	FROM (MM/DD/YYYY)	THROUGH (MM/DD/YYYY)	
ADDRESS					
CITY		STATE	ZIP		
DOCTOR'S NAME		TREATMENT DATES:	FROM (MM/DD/YYYY)	THROUGH (MM/DD/YYYY)	
ADDRESS					
CITY		STATE	ZIP		
HOSPITAL CONFINEMENT SINCE LAST REPORT					
HOSPITAL NAME					
ADDRESS					
CITY		STATE	ZIP	ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)
HOSPITAL NAME					
ADDRESS					
CITY		STATE	ZIP	ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)
HAVE YOU RETURNED TO WORK OR YOUR USUAL DAILY ACTIVITIES?					DATE
YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE INDICATE THE ACTUAL DATE YOU RETURNED TO WORK OR YOUR USUAL DAILY ACTIVITIES.					
IF YOU RETURNED TO WORK, PLEASE INDICATE ONE OF THE FOLLOWING: FULL TIME NO RESTRICTIONS <input type="checkbox"/> FULL TIME WITH RESTRICTIONS <input type="checkbox"/> PART TIME <input type="checkbox"/>					
IF YOU RETURNED TO WORK WITH RESTRICTIONS OR PART TIME, PLEASE INDICATE WORK RESTRICTIONS ON YOUR RETURN TO WORK DATE.					
PLEASE INDICATE THE DATE THESE WORK RESTRICTIONS WILL BE APPLICABLE THROUGH. (MM/DD/YYYY)					
HAVE YOU FILED FOR A CLAIM UNDER ANY OF THE FOLLOWING BENEFITS LISTED BELOW?					IF YES, TO ANY OF THE ABOVE, PLEASE SUBMIT A COPY OF THE AWARD OR DENIAL LETTER IF RECEIVED UNLESS ALREADY PROVIDED.
WORKERS' COMPENSATION ACT YES <input type="checkbox"/> NO <input type="checkbox"/>		SOCIAL SECURITY ACT YES <input type="checkbox"/> NO <input type="checkbox"/>		STATE DISABILITY YES <input type="checkbox"/> NO <input type="checkbox"/>	
DATE (MM/DD/YYYY)		SIGNATURE			

**ATTENDING PHYSICIAN'S STATEMENT**

PATIENT'S FIRST NAME		LAST NAME		M.I.
IMPORTANT: PLEASE ATTACH A COPY OF THE TEST RESULTS AND OFFICE NOTES THAT PROVIDE OBJECTIVE SUPPORT FOR YOUR PATIENT'S CONTINUING TOTAL DISABILITY.			CLAIM NUMBER	
PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		
SUBJECTIVE SYMPTOMS				
PREGNANCY				
DATE OF DELIVERY (MM/DD/YYYY)		VAGINAL <input type="checkbox"/> CESAREAN <input type="checkbox"/>		
IF NOT DELIVERED, PLEASE PROVIDE EXPECTED DELIVERY DATE (MM/DD/YYYY)				
PLEASE INDICATE ANY COMPLICATIONS THAT WOULD PREVENT PATIENT FROM PERFORMING NORMAL JOB FUNCTIONS OR USUAL ACTIVITIES.				
PLEASE PROVIDE THE FOLLOWING TREATMENT INFORMATION FOR YOUR PATIENT:				
FREQUENCY OF VISITS		DATE OF LAST VISIT (MM/DD/YYYY)	DATE OF NEXT VISIT (MM/DD/YYYY)	
DID THE PATIENT UNDERGO SURGERY? YES <input type="checkbox"/> NO <input type="checkbox"/>		IF SO, WHAT WAS THE PROCEDURE DATE(S) AND CPT CODE(S)?	DATE (MM/DD/YYYY)	CPT CODE
HOSPITAL CONFINEMENT SINCE LAST REPORT		ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)	
HOSPITAL NAME				
NATURE AND DURATION OF TREATMENT (INCLUDING THERAPY AND MEDICATION PRESCRIBED).				
WHAT IS YOUR PROGNOSIS FOR THE PATIENT'S RETURN TO THEIR OWN OCCUPATION?		DATE (MM/DD/YYYY)		
TO ANY OTHER WORK IF THEY ARE NOT ABLE TO RETURN TO THEIR OWN OCCUPATION?		DATE (MM/DD/YYYY)		
WHAT COMPLICATIONS, IF ANY, OR SECONDARY CONDITION (S) HAVE OCCURRED TO PROLONG THIS DISABILITY?				
DESCRIBE THE SPECIFIC RESTRICTIONS AND/OR LIMITATIONS THAT PREVENT THE PATIENT FROM PERFORMING HIS/HER OCCUPATION (STANDING, SITTING, REACHING, LIFTING, CARDIAC FUNCTIONAL CAPACITY, ETC...).				
IF YOU INDICATED SPECIFIC RESTRICTIONS AND LIMITATIONS, CAN YOUR PATIENT RETURN TO WORK IF THE PATIENT'S EMPLOYER CAN ACCOMMODATE THESE RESTRICTIONS AND LIMITATIONS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
PHYSICIAN'S NAME		SIGNATURE		DEGREE
ADDRESS				
CITY			STATE	ZIP
DATE (MM/DD/YYYY)		PHONE NUMBER		FAX NUMBER
<b>MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE</b>				
INDIVIDUAL PRACTITIONER'S S.S. NO.			ALL OTHERS - EMPLOYER I.D. NO.	

**EMPLOYER'S STATEMENT**

**IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION C – EMPLOYER'S STATEMENT. PLEASE NOTE: IF THE INSURED IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE THIS SECTION.**

EMPLOYEE'S FIRST NAME	LAST NAME	M.I.
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CITY	STATE	ZIP
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PHONE NUMBER	BIRTH DATE (MM/DD/YYYY) / /	CLAIM NUMBER (IF AVAILABLE)
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DATE LAST WORKED (MM/DD/YYYY) / /	DATE RETURNED TO WORK (MM/DD/YYYY) / /	FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/>	MONTHLY EARNINGS \$ ,
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POLICY NUMBER(S)
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EMPLOYEE'S OCCUPATION	DESCRIPTION OF OCCUPATION'S PRIMARY DUTIES
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WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? YES  NO  PAID? YES  NO

**IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.**

NAME
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ADDRESS
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CITY	STATE	ZIP
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PHONE NUMBER
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**PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)**

SITTING     PER DAY    WALKING     PER DAY    CLIMBING STAIRS/LADDERS     PER DAY    DRIVING     PER DAY

H H M M                      H H M M                      H H M M                      H H M M

LIFTING:  LESS THAN 15LBS     15 TO 45LBS     MORE THAN 45LBS                      STOOPING/BENDING:  NONE     SELDOM     FREQUENT

<b>TOTAL DISABILITY:</b> BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES? FROM (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> THROUGH (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>PARTIAL DISABILITY:</b> BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES? FROM (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> THROUGH (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>
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DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75% OR MORE OF HIS PRE-DISABILITY INCOME? YES  NO  IF NO, WHAT PERCENTAGE? \_\_\_\_\_ %

DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)
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EMPLOYER CONTACT NAME	CONTACT'S POSITION	DATE (MM/DD/YYYY) / /
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SIGNATURE	PHONE NUMBER	FAX NUMBER
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## FRAUD NOTIFICATIONS

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**If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:**

**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.

**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:** 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 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:** 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:** 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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA:** A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any 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.

**LOUISIANA:** 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.

**MAINE:** 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:** 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.

**MINNESOTA:** A person who files a claim with intent to defraud or helps 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 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 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.



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## CONSENT TO ELECTRONIC TRANSACTIONS, PAYMENTS AND SIGNATURE

### 1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America ("Combined") of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be delivered online to your Combined Self-Service Account. You will be notified via email when delivered. This consent unless withdrawn applies to all transactions between you and Combined.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed through our Self-Service portal at <https://my.combinedinsurance.com> or by calling the Customer Service Department.

You have the right to receive communications from Combined in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-800-225-4500, Monday through Friday between 7:30 am and 6:00 pm CST or go to [www.combinedinsurance.com/us-en/contact-us](http://www.combinedinsurance.com/us-en/contact-us) to fill out and submit a General Inquiries form. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

### 2. Consent to Electronic Payment

If you submit a payable claim, Combined may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Combined will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

### 3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Combined.

