



Short-Term Disability Claim Form Instructions

EPIC's *Short-Term Disability Claim Form* has three sections – the employee, attending physician(s), and employer must each complete their corresponding section. **AFTER your date of disability, please complete ALL three sections and gather any necessary documentation PRIOR TO submitting your claim.** Review of your claim will begin upon receipt of all three sections. By following these instructions, you will prevent temporary claim denial and allow us to process your claim more efficiently.

Section I | *Employee Questionnaire*

This questionnaire is to be completed by the employee applying for Short-term Disability benefits. Includes a Federal Income Tax Withholding Form.

Section II | *Attending Physician Statement*

This statement is to be completed by the employee's attending physician(s). Please provide any necessary documentation.

Section III | *Employer Questionnaire*

This questionnaire is to be completed by the employer's authorized representative. Please provide any necessary documentation.

Helpful Hints Regarding Your Claim

- Watch your EOBs for messages related to your claim, such as: additional requests for information, notifications regarding your claim, etc.
- If you have multiple attending physicians during your care, please have **EACH** physician complete an *Attending Physician Statement*.
- If your claim is related to an injury, please provide specific details about the incident along with any police or accident reports.
- Consult your tax advisor or group leader before completing the Federal Income Tax Withholding Form.
- Your claim (all three sections) should be completed after your disability occurs. Early submission will cause delays.

Questions/Assistance

For questions or assistance, please contact EPIC's Life and Disability Claims Department at 800-520-5750 or life&diclaims@epiclif.com.

Submitting Your Claim

Please ensure all three sections of your claim form are fully completed and signed. Please send or fax your claim form and documentation to:

The EPIC Life Insurance Company
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
Fax: 608-223-2159



Short-Term Disability Claim Form

Employee Questionnaire

1. Name			2. Date of Birth		
3. Street Address			4. Telephone		
5. City		State	Zip	6. E-mail Address	
7. Group Number & Division			8. Certificate Number and Social Security Number (required for tax purposes)		
9. Current job title with your employer			10. What is the first date you were unable to work because of this disability?		
11. Describe the daily duties of your job (Example: My job requires that I am kneeling/squatting 80% of the day and the remaining 20% walking or sitting.)					
12. Have you been continuously totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what date did you return to work? <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time					
13. Have you been continuously partially disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what date did you return to work?					
14. Describe your medical condition.					
15. Did you use sick time or vacation time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the specific dates of sick or vacation time used?					
16. Is this disability injury related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe how, when and where the injury occurred.					
17. Did your illness or injury occur as a result of engaging in any activity for pay, profit or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name and address of the employer where the illness or injury occurred.					
18. If your claim was approved or denied by the workers compensation carrier, please provide a copy of the approval or denial letter with your claim.					
19. Are you receiving any income(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: A. Social Security Disability Income: \$ _____ B. Workers Compensation Income: \$ _____ C. Other incomes (including incomes from other insurance policies): \$ _____ D. If you are receiving any income, please provide the names and addresses, policy number and the date payments began and/or ceased? _____ _____					
20. Prior to this disability claim, did you receive a diagnosis, medical care, services, treatment, advice or recommendations for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following dates: A. Diagnosis _____ D. Treatment _____ B. Medical Care _____ E. Advice _____ C. Services _____ F. Recommendations _____					
21. Please provide the names, addresses and telephone numbers of your family physician and other treating physicians. _____ _____ _____					

FEDERAL INCOME TAX WITHHOLDING

22. If you would like EPIC to withhold Federal Income Tax from your available disability benefit, please complete a **Federal Income Tax Withholding Form**.

Note for Self-funded Plans: If your employer is funding your short-term disability plan, EPIC is required by law to withhold Federal Income Taxes at a rate of 28% of your gross benefit.

AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION (This Authorization complies with the HIPAA Privacy Rule)

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Life"). "Information" may include my entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Life to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Life.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Life. I am aware that my revocation will not be effective until received by EPIC Life and will not be effective regarding the uses and/or disclosures of my Information that EPIC Life has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Life with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Life from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

I certify that the information I have provided on this form is true, complete, and accurate to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss may be subject to imprisonment, fines, denial of insurance, and/or civil damages.

Name of Claimant

Claimant's Date of Birth

Signature of Claimant or Personal Representative*

Date Signed

*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation)

MAIL OR FAX FORM TO: THE EPIC LIFE INSURANCE COMPANY
ATTN: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
life&dclaims@epiclifecom
Fax: 608-223-2159



Federal Income Tax Withholding Form

Please complete this form if you would like EPIC to withhold Federal Income Taxes from your benefit payments. EPIC recommends that you discuss this option with your tax advisor or group leader to ensure you are making the best decision based on your premium contribution. The minimum amount you may request to withhold is \$20 per week.

I am requesting The EPIC Life Insurance Company to withhold \$_____ per week from my available disability benefit payments for my Federal Income Taxes. I understand that my request is valid for the duration of my claim or 7 days after EPIC receives my written request for a change or discontinuance.

Note for Self-funded Plans: If your employer is funding your short-term disability plan, EPIC is required by law to withhold Federal Income Taxes at a rate of 28% of your gross benefit.

Name of Claimant

Claimant's Date of Birth

Signature of Claimant or Personal Representative

Date Signed

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Short-Term Disability Claim Form

Attending Physician Statement

23. Patient's Name	24. Identification Number	Date of birth
25. Date you first attended patient	26. Date you last attended patient	

27. Date sickness or injury began	
28. Diagnosis code (ICD-9 code)	29. Description
30. Medication(s) prescribed	

31. If patient was hospitalized, please provide admit and discharge dates:
Admit _____ Discharge _____

32. Is this illness or injury work related? Yes No

33. Is this illness or injury intentionally self-inflicted or attempted suicide? Yes No
If yes, please provide details:

34. Is this illness or injury resulting from weight control or treatment of obesity not caused by an organic condition? Yes No
If yes, please describe your objective findings:

35. Has surgery been done? Yes No
If yes, date of surgery _____ What procedure was performed? _____

36. To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment, advice or recommendations for this condition prior to this disability onset? Yes No
If Yes, please provide the name, address and telephone number of the referring physician.

37. **Physical restrictions/limitations (as defined in the Federal Dictionary of Occupational Titles)**

- Class 1-No limitation of functional capacity: capable of heavy work. No restrictions (0-10%)
- Class 2-Medium manual activity (15-30%)
- Class 3-Slight limitation of functional capacity: capable of light work. (35-55%)
- Class 4-Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity. (60-70%)
- Class 5-Severe limitation of functional capacity: incapable of minimum (sedentary) activity. (75-100%)

What are the patient's physical restrictions/limitations?

38. **Mental impairments (if applicable)**

- Class 1-Patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2-Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- Class 3-Patient is able to engage in only limited stress situations or engage in limited interpersonal relations (moderate limitations).
- Class 4-Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- Class 5-Patient has significant loss of physiological, psychological, personal and social adjustment (severe limitations).

What are the patient's mental impairments?

TOTAL DISABILITY

39. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

40. What date did he/she become totally disabled (continuously unable to perform the functions of his/her occupation or to work for wage or profit)?

41. Has the patient been continuously totally disabled since this date? Yes No
If no, what date was the patient no longer totally disabled?

42. What is the patient's expected return to work date?

43. Is the patient a candidate for partial disability? Yes No
If yes, refer to PARTIAL DISABILITY section below.

PARTIAL DISABILITY

44. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

45. What date did he/she become partially disabled?

46. What is the number of days or hours the patient can resume part-time work?

47. What is the patient's expected return to work date on a full-time basis?

MATERNITY

48. Is this disability due to pregnancy? Yes No

49. If disability is prior to delivery, what are the complicating factors (be specific) and expected date of delivery?

50. What date did she become totally disabled (continuously unable to perform the functions of her occupation or to work for wage or profit)?

51. What was the patient's date of delivery?

52. Type of delivery? Vaginal C-section

53. What is the patient's expected return to work date?

Physician Information

Physician's Signature	Date
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Physician Name (Please print)

Physician Address	City	State	Zip
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Physician Telephone Number

Physician Fax Number

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Short-Term Disability Claim Form

Employer Questionnaire

54. Employee Name

55. Employee Certificate Number

56. Policy Number

57. Date of Hire

58. What was the last day worked and number of hours worked that day?

59. A. Was sick time paid? Yes No If yes, please provide date(s) paid. _____

B. Was vacation time paid? Yes No If yes, please provide date(s) paid. _____

C. Was salary continuation paid? Yes No If yes, please provide date(s) paid. _____

60. Did the sickness or injury arise out of or in the course of employment? Yes No

If yes, has a workers compensation claim been filed? Yes No

If yes and the claim was denied by your workers compensation carrier, **provide a copy of the DENIAL letter with this claim.**

If no, please explain

61. Is the employee back to work? Yes No Full-Time Part-Time

If yes, please provide the return to work date and copy of physician's return to work notice.

62. If employee is partially disabled, are you able to make reasonable accommodations? Yes No

(example: an employee's job requires daily lifting and carrying of objects in excess of 25 lbs. If the physician releases the employee to return to work with a restriction of lifting and carrying a maximum of 10 lbs. for 3 weeks, can you reasonably accommodate this restriction?)

Note: If you have partial disability coverage and the employee returned to work part-time, you must include the number of hours and days worked as well as the earned wages during the week. This information **MUST** be sent, faxed or emailed to EPIC at the end of each week.

63. Employee's average weekly wage?

64. Employee's average hours per week?

65. Was the employee insured under your prior STD policy? Yes No

If yes, what was the employee's effective date of the prior policy?

66. Job title (**IMPORTANT: PLEASE ATTACH JOB DESCRIPTION**)

67. **Prior to disability, did you consider your employee able to perform (complete based upon employee's job prior to disability)?**

- Sedentary Work: Lift 10lbs maximum and occasionally carry small objects
- Light Work: Lift 20 lbs maximum and frequently lift/carry up to 10 lbs
- Medium Work: Lift 50 lbs maximum and frequently lift/carry up to 25 lbs
- Heavy Work: Lift 100 lbs maximum and frequently lift/carry up to 50 lbs
- Very Heavy Work: Lift in excess of 100 lbs and frequently lift/carry 50 lbs

68. **Did the employee perform the following tasks (prior to disability)?**

	Never	Occasionally (1-33%)	Frequently (34-56%)	Continuously (57-100%)
Push/pull when seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/pull when standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. **Assuming an 8-hour workday with two fifteen-minute breaks and 1/2-hour meal break; I expect this employee to be able to:**

(circle the number of hours for each activity.)

Sit	1	2	3	4	5	6	7	8	Continuously	With Rest
Stand	1	2	3	4	5	6	7	8	Continuously	With Rest
Walk	1	2	3	4	5	6	7	8	Continuously	With Rest
Alternately sit /stand	1	2	3	4	5	6	7	8	Continuously	With Rest

Comments: _____

FICA TAX WITHHOLDING INFORMATION

70. Indicate employee's Social Security Identification Number as shown on your employment records: _____

71. Do you contribute 100% of the premium for the employee's short-term disability coverage? Yes No

If no, what percentage of the premium for such coverage is contributed by you _____ %; by the employee _____ %

72. Is the employee's percentage subject to a cafeteria plan? Yes No

73. Employer Name _____

74. Employer Address _____ City _____ State _____ Zip _____

75. Employer Telephone Number _____

76. Employer Fax Number _____

77. Employer E-mail Address _____

78. Signature of Authorized Representative and Title _____

Date _____

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