Group Disability Claim Filing Instructions

(Not for use when filing for Physician's Expense Benefits)

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physicians Statement and return to you.
3. Have your Employer complete the Employer's Report of Claim.
4. Submit the completed:
   - **A.** Employee's Disability Benefits Application
   - **B.** Employers Report of Claim
   - **C.** Attending Physician's Statement

   To the address below or submit via our toll-free fax @ 1-800-818-3453

All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits. If you have any questions regarding completion of this form please call:

Toll Free Phone # (800)662-1113
Local Phone # (405)523-5025

American Fidelity Assurance Company

A member of the American Fidelity Group

Educational Services Division
Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160

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EMPLOYER'S REPORT OF CLAIM

EMPLOYMENT

Name of Employer: Phone No.: ( )

Mailing Address: (include street, city, state and zip code) Fax No.: ( )

Name of Employee: Social Security Number: - -

Address: (include street, city, state and zip code) Phone No.: ( )

Date of Hire: Effective date of employee's coverage: Occupation: (please attach job description)

Status of employment at time of disability: ❑ Full-Time ❑ Part-Time ❑ Leave of Absence ❑ Terminated ❑ Retired

Number of hours worked per week at time of disability:_____

Inhouse days:
First Day _____
Last Day _____

Number of contract days: _____ for _____ school year.

Has employee's status of employment changed? ❑ Yes ❑ No If yes, current status and date of status-change?_____

PREMIUMS

Does employee participate in Social Security? ❑ Yes ❑ No If no, hired after 4/1/86? ❑ Yes ❑ No

Please furnish the percentage of the employee's AFA disability premium you pay: _____%

Are the AFA disability premiums withheld before or after taxes? ❑ Before ❑ After

SALARY

SALARY AT TIME OF DISABILITY

Weekly: $ _____ Effective Date: _____

Monthly: $ _____ Effective Date: _____ ❑ 9 ❑ 10 ❑ 12 Month Work Schedule

Annual: $ _____ Effective Date: _____
(for educators)

DISABILITY

Date employee last worked:_____

Has employee returned to work? ❑ Yes ❑ No

If Yes, date returned to work: Full Time:_____ Part Time: _____

OTHER INCOME

Did Employee's disability result from employment? ❑ Yes ❑ No

If yes, name, address and phone number of Worker's Compensation carrier: _____

Has employee made a claim for or entitled to Worker's Compensation? ❑ Yes ❑ No

If yes, weekly rate of compensation: $_____

Provide: The final date the employee is entitled to fully paid sick leave _____

The **first** date the employee is entitled to differential/sabbatical pay, if any _____

The **last** date the employee is entitled to differential/sabbatical pay _____

The daily rate of differential/sabbatical pay $_____

Name, address and phone number of any other disability carrier: (include street, city, state and zip code)

Is employee eligible for disability retirement benefits? ❑ Yes ❑ No

Remember - To attach a copy of the applicable school calendar for any contracted employee.

FAILURE TO DO SO COULD RESULT IN DELAYED BENEFITS

I hereby certify that the above named employee is a member of our Group Disability Program. The information stated above is correct to the best of my knowledge and belief.

Authorized signature of employer firm or authorized official: _____

Title: _____ Date: _____

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www.afadvantage.com

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

Full Name: (last, first, middle initial) | Maiden Name | Account Number:

Residence: (street, city, state and zip code) | Social Security Number: - -

Mailing Address: (P.O. Box or street, city and zip code) | Date of Birth: / /

Telephone Number: (including area code) ( ) | ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Occupation: | Has your employment terminated? | If so, date:

Names & birth dates of spouse & dependents:

Name _____ Birth date / / | Name _____ Birth date / /

Name _____ Birth date / / | Name _____ Birth date / /

1. Date accident or illness began:

2. If accident, explain where and how it happened?

3. Have you ever had the same or similar condition in the past? ❒ Yes ❒ No

If yes, names and address of treating physicians and/or hospitals:

4. Nature of illness or injury:

5. Dates of medical treatment:

Date of next Doctors appointment:

6. If hospitalized give full name(s) and addresses of hospitals: (attach additional list if necessary)

Admit Date: ____/____/____ Discharge Date: ____/____/____

Admit Date: ____/____/____ Discharge Date: ____/____/____

7. Full names and addresses of all treating physicians: (attach additional list if necessary)

8. Is your disability related to your employment/occupation? ❒ Yes ❒ No
If yes, have you or do you intend to file for Worker's Compensation? ❒ Yes ❒ No

9. On what date did you last work?_____
Dates of total disability:
From _____ Thru _____
On what date did you return to work?
Part Time ____/____/____
Full Time ____/____/____
If not returned to work, when do you anticipate returning to work?_____

10. Please complete if you desire benefits deposited directly into your bank account.

I authorize AFAC to initiate credit entries to my account at the depository named below.This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it.

Bank/Credit Union Name: _____

Signature: _____

NOTE: You must attach a voided check to begin direct deposit.

11. If your request for benefits is approved do you want us to withhold Federal Taxes from each benefit check? ❒ Yes ❒ No

If yes, amount: $ _____ (indicate amount per month $86.00 minimum)

12. Identify other income sources and amount of income for which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement)	❒ Yes	❒ No	$____Mo.	V.A. Benefits:	❒ Yes	❒ No	$____Mo.
Dependent Social Security:	❒ Yes	❒ No	$____Mo.	Worker's Compensation:	❒ Yes	❒ No	$____Mo.
Sick Leave or Wage Continuation:	❒ Yes	❒ No	$____Mo.	Other Disability Coverage:	❒ Yes	❒ No	$____Mo
Retirement: (normal early or disability)	❒ Yes	❒ No	$____Mo.	(identify)_____			
State Disability Income	❒ Yes	❒ No	$____Mo.	**Include a copy of your award or denial letter for any source in which one has been received.**			

I hereby authorize any physician, employer, hospital, pharmacy, insurance company, Worker's Compensation carrier, Social Security office, Veterans Administration, retirement system, or other organization to release any information regarding the medical or mental health history, treatment, disability or benefits payable for this disability to the American Fidelity Assurance Company or its representative. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. By signing below I certify the above information as true and CORRECT to the best of my knowledge.

By State Law, you must be advised that:
THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing and treatment records of alcohol and drug abuse.

Signature: _____ Date: _____

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ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: Date of Birth: Account Number:

DIAGNOSIS

Diagnosis: (including complications) ICDA Code:

Is disability due to injury or sickness arising out of or in the course of patient's employment? ❒ Yes ❒ No

Is disability the result of pregnancy? ❒ Yes ❒ No If yes, type of delivery: _____

Date pregnancy was diagnosed? ____/____/____ Date of delivery:(if delivered) ____/____/____ Expected date of delivery ? ____/____/____

HISTORY

When did symptoms first appeared or accident happen? ____/____/____ Date patient first consulted you for this condition? ____/____/____

Has the patient ever had the same or similar condition? ❒ Yes ❒ No If yes, indicate when and describe:

Was the patient referred to you? ❒ Yes ❒ No If yes, full name and address of referring physician:

TREATMENT

Frequency of treatment: ❒ Monthly ❒ Weekly ❒ Other
If not under your regular care and attendance please explain.

Date of next appointment : ____/____/____

Nature of treatment being rendered (including surgery and any medications being prescribed) and the current treatment plan:

List all dates of treatment or medical attention since the disability began:

Is patient still under your care for this condition? ❒ Yes ❒ No If no, please provide the name of the current treating physician:

Has the patient been confined to a hospital: ❒ Yes ❒ No Admitted: ____/____/____ Discharged: ____/____/____

If yes, give admit and discharge dates along with name and address of hospital Admitted: ____/____/____ Discharged: ____/____/____

Name:_____ Address_____

PROGNOSIS

Dates of total disability: (unable to work) From: _____ Through: _____

Disabled from: Patients Job ❒ Yes ❒ No Any other work ❒ Yes ❒ No

Dates of partial disability: From: _____ Through: _____

If the patient is currently disabled, what is the anticipated length of disability:

❒ 1-2 Months ❒ 2-3 Months ❒ 3-6 Months ❒ 6-12 Months ❒ More than 12 Months ❒ Permanent

When, in your opinion will the patient recover sufficiently to return to work?

IMPAIRMENTS

Physical Impairments (*As defined in 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* activity (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%)

DSM-IV Diagnosis (if applicable)

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Do you believe patient is competent to endorse checks and direct the use of the proceeds thereof? ❒ Yes ❒ No

Attending Physician's Name: (print) Degree: Telephone #: ( ) - Fax #: ( ) -

Street Address: City: State: Zip Code:

Signature: Federal Tax ID #: Date: