USAble Life
Live life. You're covered.™

One Riverfront Plaza
Westbrook, ME 04092-9700
Telephone: (877) 254-0085
Fax: (207) 591-3048

Educator Disability Plan
Instructions for Filing Claims

Dear Insured:

USAble Life is pleased to provide you coverage when you are unable to work due to a covered disability. We have included these instructions and the necessary forms to assist you in the event you need to file a claim for disability benefits. Please remember that all forms must be received within 90 days of the date you stop work.

Employee Statement

1. Complete the Employee Statement in full.
2. Answer all questions or state "not applicable".
3. Review the attached Fraud Statement as it applies to your state of residence, sign and date.
4. Sign and date the Authorization form.

Employer & Attending Physician Statements

1. Obtain the statement of your Attending Physician who will certify your disability.
2. Obtain the statement of your Employer.

Return All Forms to USAble Life:

Facsimile: (207) 591-3048

Mail: One Riverfront Plaza, Westbrook, ME 04092-9700

For Questions or Assistance Call or Contact USAble Life:

Telephone: (877) 254-0085

USAble Life
Attention: Claims Department
One Riverfront Plaza
Westbrook, ME 04092-9700
Telephone: (877) 254-0085
Fax: (207) 591-3048

Statement of Claim
Educator Disability Plan
Income Benefits
Employee's Statement

Instructions

1. **Please type or print in blue or black ink.**
2. **Please make sure all questions on Employee's Statement are completed in full.**
3. **Employer's and Physician's Statements must be completed.**
4. **Authorization and Fraud Notice must be signed and currently dated.**
5. **Email, fax or mail the completed form to USAble Life.**

EMPLOYEE'S STATEMENT

Full Name (First, Middle, Last)	Social Security Number	Gender ☐ Male ☐ Female
Street Address	Date of Birth	Occupation
City, State, Zip	Telephone Numbers Home / Work	
Claim is for ☐ Accident ☐ Sickness ☐ Pregnancy	Nature of Accident or Sickness	

Date of 1st Treatment	Physician or Hospital First Treated By	First Full Day of Disability

If accident, how did the accident occur? _____

Accident Date _____ Time _____ ☐ A.M. ☐ P.M. Place _____

Was a third party responsible for accident? ☐ Yes ☐ No If Yes, third party's name _____

Third party's address _____

Identify other income sources and amount of income 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 $_____ Wk.
Retirement: (normal, early or disability) ☐ Yes ☐ No $_____ Mo. Other Disability Coverage: ☐ Yes ☐ No $_____ Wk.
Unemployment: ☐ Yes ☐ No $_____ Wk. (identify)_____

Include a copy of your award or denial letter for any source in which one has been received.

Names and addresses of all doctors consulted for **this** condition (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code

Have you ever had this or similar condition before? ☐ Yes ☐ No If yes, give particulars: Date _____

Describe_____

Names and addresses of all doctors seen for **any** condition in the past five years (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition

USAble Life

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

AZ: 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 loss is subject to criminal and civil penalties.

AR, LA, MD, RI, and WV: 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.

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

CO: 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 respect to a settlement or award from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies to the extent required by applicable law.

DE: Any person knowingly and with the intent to injure, defraud or deactivate any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: 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.

FL: 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.

HI: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

ID: Any person knowingly and with the 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.

IN: A person knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KY: Any person who knowingly and with the 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.

ME: 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.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: A person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

NM: 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.

OH: A person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

OK: WARNING: any person who knowingly and with the 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 is guilty of a felony.

OR: A person who knowingly and with the intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

PA: 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.

TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: 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.

Date _____ Signature _____

USAble Life

Authorization to Disclose, Obtain and Use Personal Information

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the Medical Information Bureau, benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

I have executed this authorization intending that it will be effective on and after

_____
(Date)

_____ _____
Signature Printed Name

Return original with your claim & retain a copy of this authorization and claim form for your records.

USAble Life
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One Riverfront Plaza
Westbrook, ME 04092-9700
Telephone: (877) 254-0085
Fax: (207) 591-3048

Statement of Claim
Educator Disability Plan
Income Benefits
Attending Physician's Statement

Instructions

1. **Physician certifying disability must complete all questions, sign and date this Attending Physician's Statement.**
2. **Fax or mail the completed form to USAble Life.**

ATTENDING PHYSICIAN'S STATEMENT

Neither the Employee nor the Employer should complete or alter any part of this statement.

Patient's Full Name (First, Middle, Last)	Date of Birth

Diagnosis & Concurrent Conditions	ICD Codes
1.	1.
2.	2.

Disability is due to
☐ Accident ☐ Sickness ☐ Pregnancy
If accident, provide how, when and where accident occurred _____

If Pregnancy, _____ (Delivery Date) ☐ Actual ☐ Estimated
Date of LMP _____
Type of Delivery ☐ Vaginal ☐ C-section

Date Symptoms First Appeared _____
Date Patient First Consulted You _____
Dates & Surgical Procedures (if any) _____

If hospitalized, ☐ Inpatient ☐ Outpatient
Date Admitted _____ Date Discharged _____
Full Name of Hospital _____
Address _____
City, State, Zip Code _____
Telephone # of Hospital _____

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

How long was or will patient be unable to work due to disability?
From _____ Through _____
Can return to work on _____
Please list all treatment dates during the month in which the disability began _____

Date of next doctor's appointment _____

List Restrictions and Limitations _____

Has patient ever had same or similar condition?
☐ No ☐ Yes Date _____

Describe any circumstances causing disability to be prolonged:

Physician's Signature	Date
Physician's Name (Please Print/Type)	Degree
Address	Telephone
City / State / Zip Code	Fax

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Employer's Statement

Instructions

1. **Employer must complete all questions, sign and date this Employer's Statement.**
2. **Fax or mail the completed form to USAble Life.**

EMPLOYER'S STATEMENT

Employee Name (First, Middle, Last)		Date of Birth	Social Security Number
Group Policy Number	Date of Hire	Coverage Effective Date	Monthly LTD Benefit $

Last Day Worked	Date Returned to Work	Base Salary $ _____
Date _____	☐ Full-Time _____	☐ Hourly ☐ Monthly
# of Hours _____	☐ Part-Time _____	☐ Weekly ☐ Annually

Employee Regularly Works _____ Hours Per Week | Employee's Occupation

Check Days Normally Worked?	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat

If on rotation, give number of days worked per week: _____

Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? ☐ Yes ☐ No

If yes, Status of claim? ☐ Pending ☐ Approved ☐ Denied ☐ Denial on Appeal

Name of Worker's Compensation Carrier: _____

Address of Worker's Compensation Carrier: _____

_____

Employee received: Salary continuation through _____ Vacation pay through _____ Sick pay through _____

Employer Name	Email address	Tax ID #
Signature	Title	Date
Name (Please print or Type)	Telephone	Fax

Street Address City State Zip Code

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