Short Term Disability Benefits Income Claim Form

This application package is divided into four sections, as follows:

Section I **Employer's Statement** - to be completed by the **employer's** authorized representative.

Section II **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits

Section III **Authorization to Obtain Information** - to be signed by the **employee**.

Section IV **Attending Physician's Statement -** to be completed by the physician who is treating **the employee.**

Mail all completed forms and documents to:

ABACUS Series
Group Disability Claim Department
P. O. Box 2993
Hartford, CT 06104-2993
Telephone Number: (866) 590-7448
Fax Number: (860) 392-3672

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR ABACUS BENEFIT MANAGEMENT SERVICE CENTER.

Short Term Disability Benefits Income Claim Form

Section I - Employer's Section

To Be Completed by the Employer

This claim is for (Employee's Name)	Social Security Number	Date of Birth
Employee's Address (Street, City, State, Zip)		

A. Information About the Employer

Company's Name	Group Policy Number
Address (Street, City, State & Zip Code)	
Name and Address of Division Where Employee Works (if different from above)	

B. Information About the Employee

Date employee was hired. ____________________

Date employee became insured under this plan.

What was the employee's regularly scheduled work week?

Hours per Week ____________

Scheduled workdays M - F ________________ Other ________________

Is Employee Enrolled In Abacus's Long Term Disability Plan ? ☐ Yes ☐ No

If "Yes," Effective Date ____________

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "Yes, attach copy.

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

If "Yes," please provide the inclusive date of coverage. From ____________ Through ____________

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No

Did STD & LTD insurance continue while on Family Leave? ☐ Yes ☐ No

Date Leave of Absence started under Family Leave Act ________________

C. Information Needed for Withholding and Reporting Taxes

What percent of this employee's STD benefit is taxable? ______%.

What percentage, if any, do you contribute towards the cost of the STD premium? ______%.

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No. If "Yes," at what percent? ______%.

Is it on a ☐ Pre or ☐ Post-tax basis? What percent of this employee's LTD benefits is taxable? ______%.

Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No. If "Yes," at what percent? ______%.

Is it on a ☐ Pre or ☐ Post-tax basis?

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)

Last day employee actually worked ______________ On that day, did the employee work a full day? ☐ Yes ☐ No

If "No," how many hours were worked? ____________

Why did employee stop working?

Is the employee's condition work related? ☐ Yes ☐ No

Has a claim been filed with Workers' Compensation?

☐ Yes ☐ No

If "Yes," send initial report of illness or injury or award notice.

Date employee is expected to return to work? ____________

Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay $ ____________

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No

Weekly Amount $ __________ Date Payments Start ________ Date Payments Will End ________

Is employee receiving Salary Continuance or Sick Leave? ☐ Yes ☐ No

Weekly Amount $ __________ Date Payments Start ________ Date Payments Will End ________

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence			
	N/A	Occasionally	Frequently	Continuously
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐

Activity	Description	Frequency	Weight
☐ Pushing			lbs.
☐ Pulling			lbs.
☐ Lifting			lbs.
☐ Carrying			lbs.

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

______________________________ ______ %
______________________________ ______ %
______________________________ ______ %

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job (e.g., through the use of technology or personal assistance)?
☐ Yes ☐ No If "Yes," explain.

H. Signature

Name (Please print or type) ______________ *Title* ______________

Signature ______________ *Date* ______________

( ) Area Code Telephone Number ______________ ( ) Area Code Fax Number ______________

ABACUS SERIES™
Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

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Section II - Employee's Section

To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information About You

Last name	First	Middle Initial	Social Security Number
Address (Street, City, State & Zip Code)			
Telephone Number ( ) Area Code	Date of Birth (Month, Day, Year)	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced
Your Employer (include division, if applicable)			

B. For an Injury, answer the following questions

When (i.e., date/time), where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Date you were first treated by a physician ____________ (Month / Day /Year)

Name of Physician

Telephone Number ( )

Address of Physician

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No
If "Yes," explain.

What aspect of your condition made you unable to work?

Are you receiving or eligible for ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other ____________
If "Yes," show policy number ____________ Name of insurer ____________
Address of insure

Weekly Amount $____________ Date Payments Start ____________ Date Payments Will End ____________

Is your condition related to your occupation? ☐ Yes ☐ No If "Yes," explain.

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If "No," explain.

D. Information About the Disability

Last day you worked before the disability ____________ (Month / Day / Year)

Did you work a full day? ☐ Yes ☐ No If "No," explain

Date you were first unable to work. ____________ (Month / Day / Year

Since that date, have you done any work? ☐ Yes ☐ No If "Yes, " please indicate dates worked, name of employer and amount earned.

If you have not returned to work, do you expect to? ☐ Yes ☐ No ☐ Part time ____________ (date) ☐ Full time ____________ (date)

E. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $ 20.00 per week). $ ________.00. **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to any request federal income tax withholding from your check.

F. Signature

With the exception of any source(s) of income reported above in Section D of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my Abacus Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period Abacus has approved my disability claim, I must report all details to Abacus, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia and Puerto Rico: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) Abacus shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of 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.

For residents of New Jersey, Arkansas, and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of Pennsylvania: 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 a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: 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."

For residents of 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.

For residents of New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

X ______________________________ **X** ______________________________

Signature of the Employee | Date

Authorization to Obtain and Release Information

Section III

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to Abacus Series a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*) ______ Date of Birth ______ Last 5 Digits of Social Security Number ______

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Abacus Series.

I ALSO UNDERSTAND that once My Information has been disclosed to Abacus Series, as permitted under this Authorization, it may be re-disclosed by Abacus Series as permitted by law or my further authorization. I authorize Abacus Series to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; or e) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; (vi) as may be lawfully required; or (vii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Abacus Series may make unless Abacus Series has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Abacus Series. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Abacus Series to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian ______ Relationship to Insured (*if signed by Guardian*) ______ Date ______

Short Term Disability Benefits Income Claim Form

ABACUS SERIES™ Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

Attending Physician's Statement of Disability

To be completed by the Attending Physician

Section IV

Name of patient	Social Security Number	Date of Birth	Height	Weight

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy If pregnancy, expected date of delivery? ____________

LMP Date ____________ Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

DIAGNOSIS

Primary diagnosis: ICD-9 Code:

Subjective symptoms:

Physical examination findings: List all test results,or enclose test:

Test ________________________ Date __________ Results ________________________

Test ________________________ Date __________ Results ________________________

Test ________________________ Date __________ Results ________________________

Blood Pressure (Systolic) ______________ Diastolic ______________ Date __________

Remarks:

TREATMENTS

Date of onset of this condition ____________ Date of next office visit: ____________

List all dates of treatment for this condition since patient ceased working

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) ____________

Name ________________ Address: ________________________ Specialty: ____________

Nature of treatment for this condition: ________________________

Was patient hospitalized for this condition? ☐ Yes ☐ No If Yes, Name of hospital ____________

Dates admitted ________________ Dates discharged ________________

Has surgery been performed? ☐ Yes ☐ No If "Yes," Date: __________

Procedure: ________________________ CPT Code: __________

Progress (Please check one.): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

What are the current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity
(Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
(Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment (*if applicable)?*

☐ Inadequate information to make assessment.

☐ Essentially good functioning in all areas. Occupationally and socially effective.

☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.

☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.

☐ Major impairment in several areas - work, family relations. Avoidant behavior, neglects family, is unable to work.

☐ Inability to function in almost all areas.

Attending Physician's Name ________________ Social Security Number or E.I.N. # ________________

Telephone Number: (____) __________ Fax Number: (____) __________ Degree __________ Specialty __________

Address ____

Signature ________________________________ Date Signed ________________