Companion Life®

DISABILITY INSURANCE CLAIM FORM

P.O. Box 100102
Columbia, South Carolina 29202-3102
803-735-1251 • 800-753-0404

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

To prevent delays, complete claim in its entirety. Incomplete claims will be returned.

PART I – INSURED INFORMATION

1. **Insured's Name** First Middle Last	2. Social Security Number	3. Date of Birth Mo. Day Yr.
4. Insured's Address Street City State Zip		
5. Insured's Sex ☐ Male ☐ Female	6. Job Description and Duties	7. If disability is due to an accident, did injury occur at work? ☐ Yes ☐ No
8. I authorize the release of any medical information necessary to process this claim. Signature _____ Date _____		

PART II – PHYSICIAN INFORMATION

9. Date first treated for this disability Mo. Day Yr.	10. Dates certified disabled and unable to work From: Mo. Day Yr. Thru Mo. Day Yr.	11. If hospitalized, date admitted Mo. Day Yr.
12. Nature of Disability ☐ Accident ☐ Sickness ☐ Maternity (If Accident or Maternity, please complete reverse side of this form.)		
13. Diagnosis	14. Diagnosis Code	15. Prognosis

16. **Physical Findings** (*list all test results, or enclose test)*

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Blood Pressure (Systolic) _____ (Diastolic) _____ (Date) _____

Remarks: _____

TREATMENT

Date of onset of this condition? _____ List all dates of treatment for this condition since patient ceased work _____

_____ Date of next office visit _____

Has patient been referred to any other physician ☐ Yes ☐ No Date(s) _____

If "Yes," name and address _____ Specialty _____

Nature of treatment for this condition *(including surgery/medications)* _____

_____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," date(s) admitted _____ date(s) discharged

Name and address of hospital(s) _____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date _____ Procedure _____ CPT Code _____

Progress *(please check one)* ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

17. **IMPAIRMENT**

What are the patient's 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.

DETAILS OF ACCIDENT OR MATERNITY CLAIM – TO BE COMPLETED BY THE PHYSICIAN

18-A. ACCIDENT:

On what date was the patient injured? _____

Where (place) was the patient injured? _____

_____

How was the patient injured? _____

_____

18-B. MATERNITY:

Estimated Date of Delivery (EDC) _____

Prenatal Complications _____

_____

_____

_____

Date of Delivery _____

Post-partum Complications _____

_____

19. I have treated the insured for the condition listed and, for the period claimed. The insured has been under my continuous care.

Physician's Name and Address (Please type or print.)

_____

_____

_____

Phone No. (Indicate area code.) _____

Date _____

Physician's Signature _____

Has the above patient been released to return to work?

☐ Yes Date to Return (Mo./Day/Yr.) _____

☐ No Approximate Date of Return (Mo/Day/Yr.) _____

☐ No Will not return to work. Disability is total and permanent.

☐ Date of Next Office Visit _____

PART III – EMPLOYER INFORMATION

20. Workers' Compensation: Is there possible Workers' Compensation liability? ☐ Yes (If yes, complete this section.) ☐ No
Date accident/sickness reported _____ Date Workers' Compensation claim filed _____
Current status of Workers' Compensation claim: ☐ Approved ☐ Denied ☐ Pending ☐ Not Filed
Name and Address of Workers' Compensation Payment Office _____

21. Is employee enrolled in the Companion Long Term Disability plan? ☐ Yes ☐ No
If "Yes," effective date: _____

22. Name and Address of Group	Phone No. and Area Code ( )	23. Group No.

24. I certify that the above insured was a full-time active employee and that he or she did not perform any duties pertaining to his or her occupation during the period claimed above in block 9.

Employer's Signature _____ Date _____

25. First Day Not at Work			26. Date Returned to Work			27. Amount of Weekly Earnings:	28. Amount of Weekly Benefit
Mo.	Day	Yr.	Mo.	Day	Yr.	$ _____	$ _____

INSTRUCTIONS FOR FILING CLAIM FOR WEEKLY DISABILITY BENEFITS

The reverse of this form should be completed by the insured employee, the employer and the insured's attending physician as soon as possible after the onset of the accident or sickness for which claim is made. If accident or maternity, details must be stated above.

The date we need a doctor's statement of continuing disability will be indicated on the check stub each week. To prevent delays in weekly disability payments, submit the doctor's statement to Companion Life 10 days before this date occurs.

Weekly disability checks are mailed to the employer's address.

When your employee returns to work, please call our Claims department to notify us immediately and then follow up with the final claim. Notifications can be faxed to:

(803) 735-1251
(803) 754-1153 FAX

Claims should be forwarded to:

Companion Life Insurance Company
Attention: Claims Department
P.O. Box 100102
Columbia, South Carolina 29202-3102
www.CompanionLife.com

By furnishing this blank form and investigating the claim, Companion Life Insurance Company shall not be held to admit the validity of any claim, or to waive or breach any terms or conditions of the policy.