



*P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080*

Group Disability Claim Application

Employer: _____

Group Policy No: _____



MEDICO®

LIFE AND HEALTH INSURANCE COMPANY

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To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays.

The application for benefits requests information that is necessary to the speedy and accurate administration of your claim. If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (not applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization and Disclosures

You (the employee) must fully complete the "Authorization", page 2. This will allow us to secure additional information (if necessary) to make a decision on your claim.

Section 2: Employee's Statement

Fully complete the section "To Be Completed By Employee", page 3.

Section 3: Employer's Statement

Have the employer fully complete the section "To Be Completed By Employer", page 4.

Section 4: Physician's Statement

Have the attending physician complete the section "To Be Completed by Physician", page 5. Please complete the top line with your name, date of birth and social security number before giving the form to your physician.

When all sections of this form have been completed, send it to us at the above address by mail or fax.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.



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AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION

Section 1: To Be Completed By Employee

To:

- Physicians and other Medical Professionals
- Consumer Reporting Agencies
- Employers
- Group Policyholders, Contract Holders/Vendors, Health Benefit Plan Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration, Veteran's Administration, Railroad Retirement Board and the Jones Act Administration)
- Hospitals and other Medical Care Institutions
- Insurers
- Prepaid Health Plans
- State Vocational Rehabilitation agencies and other providers of Rehabilitation Services
- Medical Information Bureau (MIB) or other Companies which collect health and insurance claim information

You are authorized to provide any information related to my medical condition and to job modifications/ accommodations with my current or future employer to:

- The plan administrator or claim administrator of any benefit plan under which I may be a participant,
- Medico Life and Health Insurance Company and its affiliated and associated companies, and
- Claims investigators, attorneys, and service consultants and other personnel involved in the administration, evaluation, analysis and management of the plan and/or claim (such individuals and entities are hereinafter collectively referred to as Medico Life and Health Insurance Company).

This includes, but is not limited to, any:

- Records, test results, data, and information concerning medical care, history, diagnosis, prognosis, treatment, and supplies
- Employment related information
- Income related information
- Information from credit reporting bureaus or other consumer reporting agencies
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid, (hereinafter collectively referred to as "Information").

I understand that the Information will be used for the purpose of evaluating, analyzing, managing and/or administering my claim for short term disability benefits, long term disability benefits, salary continuation, workers' compensation and/or any other health benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), for assessing and developing a vocational rehabilitation plan, and for other business purposes in connection with the administration of the Benefits Program.

I further authorize Medico Health and Life Insurance Company to re-disclose any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any benefit plan under which I may be a participant, claims investigators, attorneys, service consultants and any other entities, including the claimant's treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. Medico Health and Life Insurance Company shall require such individuals to adhere to requirements and guidelines intended to protect and preserve the confidential nature of the Information.

I understand that this authorization shall remain in force for the duration of my claim for benefits under the Benefits Program or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization and to inspect and copy any written information disclosed. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed. I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of my initial authorization, may impair the ability of Medico Health and Life Insurance Company to process my claim and may be a basis for denying or terminating my claim for benefits.

Claimant's Signature: _____

Claimant's Date of Birth: _____

Claimant's Full Name: _____

Employer: _____

Claimant's Address: _____

Date: _____



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EMPLOYEE'S STATEMENT

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1 Employee Name		2 Social Security No.	
Street/Box/Apt.		3 Phone No. ()	
City, State, Zip		4 Date of Birth	
5 Height	6 Weight	7 <input type="checkbox"/> Male <input type="checkbox"/> Female	8 Employer Name
9 Occupation	10 List Occupation Duties		
11 Date of accident or date of first symptoms		12 Last Day Worked	13 Are you unable to work due to? (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy
14 Date you Returned to Work		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
15 If you have not returned to work, when do you expect to return?		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
16 Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms			

17 Is your accident or illness related to your occupation? Yes No
If yes, explain:

18 Have you filed a Workers' Compensation Claim? Yes No If no, do you intend to? Yes No
If no, explain:

19 When were you first treated for your illness or accident?

Hospital	Address	Date(s)
Doctor	Address	Date(s)

20 Have you ever had same or similar condition in the past? Yes No If yes, list name and address of Hospital/Doctor

Hospital	Address	Date(s)
Doctor	Address	Date(s)

21 Are you receiving? (check those benefits you are receiving)

<input type="checkbox"/> Workers' Compensation	Amount \$ _____ Begin _____ End _____	<input type="checkbox"/> Unemployment	Amount \$ _____ Begin _____ End _____
<input type="checkbox"/> Social Security	Amount \$ _____ Begin _____ End _____	<input type="checkbox"/> Other (Indiv. or Group)*	Amount \$ _____ Begin _____ End _____
<input type="checkbox"/> State Disability	Amount \$ _____ Begin _____ End _____	<input type="checkbox"/> Auto Ins. Wage Replacement*	Amount \$ _____ Begin _____ End _____

*If yes, give name and address of Insurer

Insurer Name(s)	Address

22 Single Married Divorced Widowed **23** If married, spouse's name and Social Security Number **24** Spouse Date of Birth

25 Is Spouse Employed? Yes No **26** List Children under age 25 (Names and Dates of Birth)

27 If benefits are approved, do you want the minimum \$20.00 per week withheld from your check for Federal Income Tax Purposes? Yes No
If you want more withheld, please state dollar amount you want withheld \$ _____

The above statements are true and complete to the best of my knowledge and belief. Your signature is required for benefit consideration.

Signature **X** _____ Date _____



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EMPLOYER'S STATEMENT

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received.
Write "NA" in non-applicable sections.

1 Employee's Name		2 Social Security No.	
Street/Box/Apt.		3 Date of Birth	
City State, Zip		4 Regularly Scheduled Hours Per Week	
5 Date of Hire	6 Employee's STD Effective Date	7 Employee's LTD Effective Date	8 Occupation

9 Policy No.	10 Policy Division No.	11 Policy Class
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12 Employee's Work Schedule Full Time Part Time Exempt Non-Exempt Seasonal

13 Check Regular Workdays Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

14 If not at work when Disability began, (check status and provide date) **15** How was employee paid? (check appropriate box)

Terminated Leave of Absence Other (Specify) _____ Hourly Monthly Salary and Bonus

Laid Off Sick Leave Date _____ Weekly Commissions Commissions Only

Vacation Resigned Biweekly Salaried Salary and Commissions

16 Salary Prior to Date Last Worked	Base Weekly Wages \$ _____	17 Date Last Salary Increase	19 Comments:
	W-2 Earnings \$ _____		
	Overtime \$ _____		
	Commissions \$ _____		
	Bonus \$ _____		
18 Employee Work Schedule at Time Last Worked			
_____ Days Per Week			
_____ Hours Per Week			

20 Date Last Worked	21 Hours Worked That Day	22 Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Date _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
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23 Date Paid Through _____ For Salary Continuation Vacation Accrued Sick Pay

24 Does employee contribute toward the STD premium? Yes No If yes, Pre-Tax Post-Tax

If Post-Tax _____% paid by employer _____% paid by employee

25 Does employee contribute toward the LTD premium? Yes No If yes, Pre-Tax Post-Tax

If Post-Tax _____% paid by employer _____% paid by employee

26 Employee is Eligible for	Yes No		If yes, Weekly or Monthly Amount	Wk. Mo.		Provider Name/Address	Date Benefits Begin Through	
	Salary Continuation	<input type="checkbox"/>		<input type="checkbox"/>	\$		<input type="checkbox"/>	<input type="checkbox"/>
Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Retirement Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Has Workers' Comp. claim been filed?	<input type="checkbox"/>	<input type="checkbox"/>	If Workers; Compensation has been denied, submit copy of denial with this claim.					

27 Does your company have a rehire or return to work policy for disabled employees? Yes No

What is the name of the person we should contact if we identify a return to work option?

28 Name/Address of the employee's medical insurance carrier or HMO (provide policy or ID No.)

29 Employer's Name		Phone No. ()	
Address Street		City	State Zip
Signature (The above statements are true and complete to the best of my knowledge)			Date
X			

A Job Description is required if employee is out of work more than 6 weeks.



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PHYSICIAN'S STATEMENT

Section 4: To Be Completed By Physician

Patient Name		Date of Birth	Social Security No.
How long was/will patient be unable to work? From _____ Through _____			
1 Patient is/was unable to work due to: (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy			
2 Diagnosis (include complications and ICD code)		If Pregnancy, estimated delivery date	
3 When did symptoms first appear or accident happen?	4 Date you advised patient to stop working	5 Is condition due to injury or illness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6 Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state when and describe			
7 Date of First Visit	8 Date Last Visit	9 Frequency of Visits	
10 Objective Findings (X-rays, EKGs, lab data and clinical findings)		11 Subjective Symptoms	
12 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency			
13 Names and addresses of other physicians			
14 Has patient been hospitalized? If yes, give name and address <input type="checkbox"/> Yes <input type="checkbox"/> No From _____ To _____			
15 Restrictions (what the patient SHOULD NOT do)		16 Limitations (what the patient CAN NOT do)	
17 Mental Impairment (if applicable) Provide 5 AXIS Diagnosis			
I		IV	
II		V	
III			
18 If this is a cardiac condition, what is the functional capacity? (American Heart Association) <input type="checkbox"/> Class 1 - No Limitation <input type="checkbox"/> Class 3 - Marked Limitation <input type="checkbox"/> Class 2 - Slight Limitation <input type="checkbox"/> Class 4 - Complete Limitation			
19 Has maximum medical improvement been achieved? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when do you expect a fundamental change? <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 3-4 weeks <input type="checkbox"/> 5-6 weeks <input type="checkbox"/> more than 6 weeks			
20 If employer can accommodate patient's limitations and restrictions, is patient able to return to work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No What date could employment begin _____			
21 Physician Name (Please Print)			Degree
Specialty	Phone No.	Fax No.	
Address	City	State	Zip
Signature (No Stamp) X	Tax ID No.	Date	