Continental American Insurance Company
P.O. Box 427, Columbia, SC 29202
Phone: 1-866-849-0011 Fax: 1-866-849-2970

Short-Term Disability Claim Form Instructions

1. **Complete Claimant sections:**

   - Sections I and II (To be completed by the Employee). Please be sure to also sign and date the medical authorization section.
   - Review your portion of the claim form for completeness.

2. **Have your Health Care Provider complete Page 2 of this form (Attending Physician Statement).**

   - Do not complete any portion of this section yourself.

3. **Employment Information**

   - This is needed to verify the dates that you were unable to work due to your disability.
   - This can be completed by your supervisor or union representative.

4. Once the entire form has been completed, please mail or fax it to:

   Continental American Insurance Company
   P.O. Box 427
   Columbia, SC 29202

   Fax: 1-866-849-2970

If you have any questions regarding the materials enclosed, please contact Continental American's Customer Service Department Monday through Friday from 9 a.m. to 6 p.m. Eastern Time at 1-866-849-0011.

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SHORT TERM DISABILITY CLAIM FORM

CLAIMANT'S STATEMENT • PLEASE READ THE INSTRUCTIONS BEFORE COMPLETING

PERSONAL DATA – SECTION I

NAME (Last, First, Middle Initial)		SOCIAL SECURITY NO.	EMPLOYEE ID	
ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH	SEX ☐ M ☐ F	PHONE NUMBER	EMAIL ADDRESS	

CLAIM DATA – SECTION II

DESCRIBE HOW AND WHERE THE ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS	WHAT WERE YOUR FIRST SYMPTOMS?
IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION ☐ NO ☐ YES IF YES, DATE REPORTED TO EMPLOYER:	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

DATE YOU WERE FIRST TREATED FOR YOUR ILLNESS OR INJURY

TREATED BY:

Doctor: ____
Name Street Address City State Zip Code

____
Phone Numer Fax Number Email

Hospital/Clinic: ____
Name Street Address City State Zip Code

____
Phone Numer Fax Number Email

EMPLOYMENT DATA – SECTION III (To be completed by your Union Representative or Supervisor)

EMPLOYER'S NAME	UNION REP./SUPERVISOR/MANAGER	PHONE NUMBER (WORK)	EMPLOYEE OCCUPATION
DATES EMPLOYEE DID NOT WORK FROM THROUGH	UNION REPRESENTATIVE SIGNATURE	DATE	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ NO ☐ YES

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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 loss is guilty of a crime and may be subject to fines and confinement in state prison.

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate or administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

Claimant's Signature: Date:

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Columbia, South Carolina 29202
Phone (866) 849-0011

SHORT TERM DISABILITY CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT (To be completed by your current treating physician)

PATIENT'S NAME		DATE OF BIRTH
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	DATE PATIENT CEASED WORK BECAUSE OF DISABILITY?	HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐YES ☐ NO DATE:

IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENTS EMPLOYMENT? ☐ NO ☐ YES IF "YES," DATE ACCIDENT OCCURRED: ________________________.	NAMES AND ADDRESSES/ REFERRING OR OTHER TREATING PHYSICIANS

DIAGNOSIS

DIAGNOSIS (INCLUDING COMPLICATIONS)	ICD CODE:	SUBJECTIVE SYMPTOMS	IF PREGNANT (EDC):
OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS.)			

TREATMENT

DATE FIRST TREATED FOR THIS CONDITION	LAST DATE TREATED FOR THIS CONDITION	FREQUENCY ☐ WEEKLY ☐ MONTHLY ☐ OTHER

NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)	DID PATIENT HAVE SURGERY? ☐ NO ☐ YES DATE:
	DESCRIBE SURGERY:

PROGNOSIS

HAS THE PATIENT: ☐ RECOVERED? ☐ IMPROVED? ☐ UNCHANGED? ☐ RETROGRESSED?	IS THE PATIENT: ☐ AMBULATORY? ☐ HOUSE CONFINED? ☐ BED CONFINED? ☐ HOSPITAL CONFINED?
HAS THE PATIENT BEEN HOSPITAL CONFINED? ☐ NO ☐ YES CONFINED FROM____________________TO____________________.	IF YES, GIVE NAME AND ADDRESS OF HOSPITAL:
IS THE PATIENT NOW TOTALLY DISABLED FROM? PATIENT'S JOB? ☐ NO ☐ YES ANY OTHER WORK? ☐ NO ☐ YES	DATE PATIENT BECAME DISABLED DUE TO PRESENT CONDITION?
WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION? ☐ 1 MO. ☐ 1-3 MO. ☐ 3-6 MO. ☐ 6-9 MO. ☐ 9-12MO. ☐ NEVER	WHEN DO YOU ANTICIPATE A RETURN TO WORK?

IMPAIRMENTS

PHYSICAL IMPAIRMENTS (As defined in the 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. (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%)

RESTRICTIONS AND LIMITATIONS (What specific activities is the patient incapable of performing)

REMARKS

REMARKS (Additional comments regarding the patient's condition)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

NAME (Attending Physician) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	