



Beginning Monday, April 5, 2010, US Able Life's Short Term Disability customers may call our Telephonic Claims toll-free line to provide notice of a disability.

The toll-free line is **866-412-9929** and our Short Term Disability Specialists will be available from 7:30 a.m. to 4:00 p.m. Central Time.

Employees, or the authorized employer representative calling on behalf of the employee, will be asked for the following information:

- Employee's First and Last Name
- Employee's Social Security Number
- Employee's Date of Birth
- The Employer/Group Name for which the employee works
- Employee's Gender
- Verification of mailing address
- Details of the disability

The Employee, or group contact person, may be asked additional pertinent questions regarding the disability, the individual or the situation during the telephone call.

This telephonic report will take the place of the Employee's Statement. To complete the claim notification process, the following forms should be mailed or faxed to US Able life within 10 business days to ensure prompt review of claims:

- Employee Authorization
- Fraud Notice
- Attending Physician's Statement
- Employer's Statement

Claimants not wishing to use the telephonic system should submit a claim by completing the Employee's Statement along with the documents listed above. Complete STD claim packets with instructions are located at [www.USABLELife.com](http://www.USABLELife.com).

If you have questions, please contact your group marketing representative.



P.O. Box 1650  
Little Rock, AR 72203-1650

## 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 US Able 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.



P.O. Box 1650 · Little Rock, Arkansas 72203-1650

## 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





Attention: Claims Department  
P.O. Box 1650  
Little Rock, Arkansas 72203-1650  
Telephone (800) 370-5856 Fax (501) 235-8417  
E-mail: claims@usablelife.com

## Statement of Claim Short Term Disability Income Benefits Employer's Statement

### Instructions

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

EMPLOYER'S STATEMENT								
Employee Name (First, Middle, Last)				Date of Birth		Social Security Number		
Group Policy Number			Date of Hire		Coverage Effective Date		Weekly STD Benefit \$	
Last Day Worked Date _____ # of Hours _____		Date Returned to Work <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____			Base Salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually			
Employee Regularly Works _____ Hours Per Week								
Check Days Normally Worked?		<input type="checkbox"/> Sun	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If yes, Status of claim? <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> 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	
<b>FRAUD WARNING:</b> 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.								