ASI

Association Services, Inc.

Specializing in Employer Group Health & Payroll Worksite Insurance Products

SAMPLE CLAIM LETTER

NAME
ADDRESS LINE 1
ADDRESS LINE 2

Reference to: Short Term Disability Claim

Enclosed is a American Fidelity disability claim form. **Please complete the form and return to**

ASI

28975 S Satsuma Road, Suite A

Livingston, LA 70754

Only use the "DIRECT DEPOSIT AUTHORIZATION" if you want payment directly deposited into a personal account (attach voided check or letter from your bank with information). You must complete the "EMPLOYEE – INITIAL DISABILITY CLAIM FORM" (page 1). Your **physician** needs to complete the "PHYSICIAN – INITIAL DISABILITY CLAIM FORM" (page 2) Your **employer** needs to complete the "EMPLOYER – INITIAL CLAIM FORM" (page 3). **Please make sure all information is complete before returning!** If you should have any questions, please give us a call. Thanks and have a blessed day!

Sincerely,

Association Services Staff

28975 S. Satsuma Road, Suite A
Livingston, LA 70754
(225) 435-0400 / 888-928-9222
Fax (225) 435-0403
www.asi-ins.com

American Fidelity Assurance Company
A member of the American Fidelity Group

ASSOCIATION and WORKSITE DIVISION
BENEFITS DEPARTMENT
P.O. Box 268898
Oklahoma City, OK 73126-8898

Group Disability Claim Filing Instructions

1) Complete "Payment Information Below" Tell us how you would like to receive benefit payments if payment is approved.
2) Complete "Employee – Initial Disability Claim Form" in full.
3) Have treating physician complete the "Physician – Initial Disability Claim Form" and return to you.
4) Have your Employer complete the "Employer – Initial Claim Form" and return to you.
5) Submit all completed forms to AWD Benefits Dept, P.O. Box 268898, Oklahoma City, OK 73126-8898 or you may fax completed forms to our Toll Free Fax Number (888)243-3453.

If you have any questions when completing this form, please call: Toll Free Number - (800) 437-1011

PAYMENT INFORMATION:

Please select one payment option below by checking the appropriate box.

- ❑ **Direct Deposit** - If you have a checking account this is the most efficient way to receive your benefit payments.
- ❑ **Debit Card** - A Debit Card account will be applied for through First Fidelity Bank of Oklahoma City, OK.
- ❑ **Check** - Check written by American Fidelity Assurance and forwarded to your mailing address of Record.

Note: A signature and additional information is required when choosing Direct Deposit or Debit Card option. Be sure to complete the appropriate section below.

CHECKING DIRECT DEPOSIT AUTHORIZATION

IMPORTANT: Funds from direct deposits will **NOT** become available to use any earlier than 3-4 business days following the date the benefits are approved and the credit entry is initiated to your account. If you have already filed a Direct Deposit Authorization Agreement, do not complete another, unless your Bank or Credit Union account information has changed.

DIRECT DEPOSIT INSTRUCTIONS: Complete and sign the form below and attach a voided/cancelled check to AUTHORIZATION AGREEMENT if selecting direct deposit into your current checking account. A deposit slip is **NOT** acceptable.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS: I authorize American Fidelity Assurance Company to initiate credit entries to my checking account at the depository named below. This authorization is to remain in full force and effect until the Company has received written notification from me of its termination in such time and in such a manner as to afford the Company and the Depository opportunity to act on my request.

BANK/CREDIT UNION NAME: _____
MAILING ADDRESS: _____
CITY, STATE, ZIP CODE: _____
BANK/CREDIT UNION PHONE NUMBER: _____ YOUR SOCIAL SECURITY NUMBER: ____-____-_____

FOR DIRECT DEPOSIT ATTACH VOIDED/CANCELLED CHECK

DEBIT CARD PAYMENT AUTHORIZATION

IMPORTANT: Funds from Debit Card Deposits will **NOT** become available to use any earlier than 3-4 business days following the date the benefits are approved and the credit entry is initiated to your Debit Card Account. If you have already completed a Debit Card Authorization Agreement and your card is still active, do not complete another. If you are not sure if you card is still active please contact First Fidelity Bank N.A. at 1(800)299-7047.

AUTHORIZATION AGREEMENT FOR DEBIT CARD ACCOUNT: I hereby request and authorize American Fidelity Assurance Company to submit my application for a Debit Card Account with First Fidelity Bank N.A. of Oklahoma City, Oklahoma under my name. Upon approval and opening of this requested account. I understand the account will be used for deposits of my benefit payments from American Fidelity Assurance Company. I further understand that charges will be applied to my account balance from the use of this card; some of those charges include the following.

- ATM Withdrawal (Domestic) = 5 free per month, $3.00 per withdrawal thereafter
- ATM Withdrawal (International) = $3.00 per withdrawal
- Balance Inquiry = $1.00 per inquiry
- No charge for IVR phone or website inquiry
- POS (Point-of Sale) Denial Fee = $1.00 per denial
- Paper Statement = $1.00 per month
- No Charge for Internet Statements
- Inactive Account Fee = $5.00 after 90 days of account inactivity
- Card Replacement = $10.00
- Pin replacement = $5.00
- Expedited Card Delivery = $25.00
- Check Issuance Fee (to close account) = $10.00
- Negative Balance Fee = $15.00

Direct Deposit -or- Debit Card Authorized Signature:

PRINT NAME: _____ DATE: _____

SIGNED: _____

American Fidelity Assurance Company

A member of the American Fidelity Group

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

EMPLOYEE - INITIAL DISABILITY CLAIM FORM

WARNING: **Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.**

Name:	Social Security Number:	Date of Birth:
Complete Mailing Address:	Complete Resident Address:	Telephone Number:

Do you have dependents under age 18? Yes ❑ No ❑ If yes, please list birth dates below:

1) Please list medical condition or accident causing disability:

2) If disability is the result of an accident, please explain in detail where, when, and how accident happened. If necessary, attach additional page:

3) Is your disability the result of your employment? Yes ❑ No ❑ If yes, please submit copy of Workers' Compensation award or denial letter.

4) Please list all dates of medical treatment pertaining to current disability:

5) Have you ever had or been treated for same or similar condition? Yes ❑ No ❑ If yes, please explain:

6) Please list name and phone number of primary care and treating physician(s):

Primary Care: _____ Treating: _____

7) Date Last Worked:

Date Returned to Work:

8) If you *have not* returned to work, what is the anticipated return date?

❑ Full Time: _____

❑ Part Time: _____

9) If your request for benefits is approved, do you want Federal Taxes withheld from each benefit check? Yes ❑ No ❑

If yes, please indicate dollar amount below:

(Minimum amount required is $87 per month.) $_____

10) Please identify other income sources and amounts of income which you are receiving or may be entitled to receive during this disability:

Social Security - Disability ❑ Retirement ❑	Yes ❑ No ❑	$_____	V.A. Benefits	Yes ❑ No ❑	$_____
Dependent Social Security	Yes ❑ No ❑	$_____	Sick Leave or Wage Continuation	Yes ❑ No ❑	$_____
State Disability	Yes ❑ No ❑	$_____	Retirement (normal, early, or disability)	Yes ❑ No ❑	$_____
Unemployment	Yes ❑ No ❑	$_____	Workers Comp	Yes ❑ No ❑	$_____
Other Group Disability Coverage	Yes ❑ No ❑	$_____			

Include a copy of **your award or denial letter** from any source that you have received.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans: d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in the caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial of benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, AWD Benefits Department, P.O. Box 268898, Oklahoma City, Oklahoma 73126-8898 or calling toll free 1-800-437-1011. I understand that my right to revoke this authorization is limited to the extent that AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original. I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations.

For health insurance coverage, this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. For Arizona residents, release of HIV/AIDS released information can only be disclosed for a period not to exceed 180 days from the date shown below.

Signature _____ Print Insured's/Patient Name _____ Date_____

Please retain a copy for your personal records, or you may request a copy from our company.

FAILURE TO SIGN & DATE FORM WILL DELAY BENEFITS

BN-667-0809

American Fidelity Assurance Company

A member of the American Fidelity Group

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

PHYSICIAN - INITIAL DISABILITY CLAIM FORM

Patient's Name: | Social Security Number: | Date of Birth:

Diagnosis: Please list diagnosis resulting in patient's *temporary* total disability (including complications)

Diagnosis: _____ ICD9 Code: _____

Diagnosis: _____ ICD9 Code: _____

Is disability the direct result of patient's employment? Yes ❑ No ❑

Is disability the result of a pregnancy? Yes ❑ No ❑ If yes, date pregnancy was diagnosed:

Delivery date: (if delivered) Expected delivery date: (if not delivered)

Prognosis: Please list date(s) of temporary total disability (unable to work) From: _____ Through: _____

If patient is currently totally disabled, please indicate the anticipated length of disability by checking the appropriate box below:

Months: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 or Permanently Disabled ❑ or Other ❑ _____

Impairment: **List functional limitations/restrictions that render your patient *temporarily* totally disabled:**

History: Was the patient referred to you? Yes ❑ No ❑ If yes, please provide name and phone number of referring physician:

Date symptoms first appeared or accident happened: | Date patient first consulted you for this condition:

Are you aware if this patient has ever had the same or similar condition? Yes ❑ No ❑ If yes, please provide explanation including first date of onset.

Treatment: Is patient still under your care? Yes ❑ No ❑ If yes, date of next appointment: _____

List all treatment dates: _____

Please describe treatment plan: _____

If patient is no longer under your care, please provide name and phone number of current physician: Unknown ❑

Has patient been confined to a hospital? Yes ❑ No ❑ Admitted: _____ Discharged: _____

Hospital Name: _____ Phone Number: _____

If surgery is/was necessary, please list procedure(s): _____

Date scheduled: Date performed:

Primary Care Physician for Patient:

Attention Physician: This form documents your verification that the above named individual is totally disabled from their occupation. You will be asked periodically for updates related to the individual's disability and treatment plan.

Primary Care Physician's Name: (please print)	Degree:	Specialty:
Street Address:	City:	State/Zip Code:
Office Phone Number:	Fax Phone Number:	Federal Tax ID Number:
Form completed by:	Title:	

Signature of Physician: Date:

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Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

EMPLOYER - INITIAL CLAIM FORM

Employee Name:	Social Security Number:
Occupation:	Hire Date:

STATUS OF EMPLOYMENT: Full Time: ❑ Part Time: ❑ Hours per day: _____ Days per week: _____

If employee's status has changed, please provide date _____ and check appropriate status change box:

Lay Off: ❑ Leave of Absence: ❑ Terminated: ❑ Retired: ❑

Date last worked? _____

Has employee returned to work? Yes ❑ No ❑ Return date: _____ Full Time ❑ Part Time ❑

SALARY AT TIME OF DISABILITY:

Hourly: $_____ Monthly: $_____

W-2, For Previous Calendar Year: $_____ Year-to-date, Current Calendar Year $_____

DISABILITY PREMIUMS:

Are the employee's disability premium contributions deducted pre-tax ❑ or post-tax ❑?

What percentage of the disability premiums do you pay (employer)? _____%

Are Social Security taxes withheld from employee's pay check? Yes ❑ No ❑

Date that last disability premiums deducted from payroll: _____ Amount deducted: $_____

WORKERS COMPENSATION:

Is disability the result of work related injury/illness? Yes ❑ No ❑

If yes, has a Workers' Compensation claim been filed? Yes ❑ No ❑

Please provide name and phone number of Workers' Compensation carrier: Name: _____ Phone # _____

OTHER SOURCES OF INCOME:

Is the employee receiving or eligible to receive any of the following?

	Yes	No	Amount	Wk	Mo	Company Name and Phone Number	Dates Benefits Begin	Dates Benefits End
Other Group Disability	❑	❑	$	❑	❑			
Salary continuation	❑	❑	$	❑	❑			
Sick Leave	❑	❑	$	❑	❑			
PTO/PPT	❑	❑	$	❑	❑			
Other (Bonus, etc)	❑	❑	$	❑	❑			
Retirement/Pension	❑	❑	$	❑	❑			

Form completed by: (please print)	Title:	Phone Number & Extension:	
Employer Name:	Office Phone Number:	Fax Number:	
Street Address:	City:	State:	Zip Code:
Signature:		Date:	

BN-667-0809

This documents that the above statements are true and complete to the best of my knowledge.