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 Continuing 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**

**You** must complete the "EMPLOYEE – CONTINUING DISABILITY CLAIM FORM" (page 1). Your **physician** needs to complete the "PHYSICIAN – CONTINUING DISABILITY CLAIM FORM" (page 2). **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

**American Fidelity Assurance Company**

A member of the American Fidelity Group

**Mail to:** American Fidelity Assurance Company
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

# REQUEST FOR CONTINUING DISABILITY BENEFITS - SUPPLEMENTAL

***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.**

## INSTRUCTIONS TO THE INSURED

1. Complete and sign the "Employee - Continuing Disability Claim Form."
2. Have the physician treating you complete the "Physician – Continuing Disability Claim Form" and have it returned to you.
3. Submit all completed claim forms to the address/fax number above.
4. If you prefer to have benefits directly deposited into your checking account, please contact our office by calling the phone number above or go to www.afadvantage.com for online assistance.

## EMPLOYEE – CONTINUING DISABILITY CLAIM FORM

Name: Social Security Number:

Complete Mailing Address: Telephone Number:

1. Are you currently working? Yes ☐ No ☐
   If yes, when did you return to work? If no, when do you expect to return to work?
2. List your current daily activities:
3. Have any other medical conditions or injuries happened since the last report? Yes ☐ No ☐ If yes, please explain:
4. Has your employment terminated? Yes ☐ No ☐ If yes, list the termination date:
5. If your request for Benefits is approved, do you want Federal Taxes withheld from each benefit check? Yes ☐ No ☐

   If yes, indicate dollar amount: (Minimum amount required is $87 per month) $
6. **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 ☐ $_____ | | |
| 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**

# PHYSICIAN – CONTINUING DISABILITY CLAIM FORM

**PATIENT NAME:** | **SOCIAL SECURITY NUMBER:**

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

Diagnosis: _____ ICD9 Code: _____

Diagnosis: _____ ICD9 Code: _____

**TREATMENT:** Is the patient still under your care? Yes ❑ No ❑ If yes, please provide date of next appointment: _____

Please describe treatment plan for the next 3-6 months: _____

If no, please provide discharge date and reason for discharge: _____

Please provide name and phone number of current physician: Unknown ❑

**DATES OF SERVICE:** Please provide dates of medical attention since last report:

**EXTENT OF DISABILITY:**

Is patient currently temporarily totally disabled? (unable to work) Yes ❑ No ❑

If no, please provide return to work date: _____

If yes, please provide temporary total disability dates:

Any Occupation: From: _____ Through: _____

Own Occupation: From: _____ Through: _____

Is patient a suitable candidate for a rehabilitation program? Yes ❑ No ❑

Is patient partially disabled? Yes ❑ No ❑ *From:* _____ *Through:* _____

Please list restrictions:

**PHYSICAL IMPAIRMENTS:** (*As defined in 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 activity *(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%)

Please list functional limitations/restrictions that render your patient temporarily totally disabled:

**HOSPITAL DISCHARGE INFORMATION:** Has patient been hospitalized since last report? Yes ❑ No ❑

Name of hospital: _____ Admission date: _____ Discharge date: _____

| | | |
|---|---|---|
| *Physicians Name: (please print)* | Degree: | Specialty: |
| Street Address: | City: | State: Zip Code: |
| Form completed by: (Name/Title) | | Office Phone Number: |
| Physician's Signature: Date: | | Fax Number: |

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

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