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 Public Life 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. (Attached voided check or letter from bank with routing and accounting number) Your **employer** needs to complete the "EMPLOYER - INITIAL CLAIM FORM" (page 1). **You** must complete the "EMPLOYEE - INITIAL DISABILITY CLAIM FORM" (page 2). Also, **you** must sign and date the "AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION" (page 4). Your **physician** needs to complete the "PHYSICIAN - INITIAL DISABILITY 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 Public Life Insurance Company
A member of the American Fidelity Group

Claims Department
P. O. Box 925
Jackson, MS 39205-0925

Group Disability Claim Filing Instructions

IMPORTANT: All portions of this claim form must be completed ***after*** disability begins to avoid undue delay in processing claimant's request for benefits. If you have any questions when completing this form, please call:

Phone Number – (601) 936-6600 or Toll Free Number – (800) 256-8606

1. Complete "Employee – Initial Disability Claim Form" in full.
2. Have treating physician complete the "Physician – Initial Disability Claim form" and return to you.
3. Have your Employer complete the "Employer – Initial Claim Form" and return to you.
4. Complete the Direct Deposit Authorization Agreement below if you prefer funds to be deposited directly into your checking account.
5. Submit all completed forms to the Claims Department, PO Box 925, Jackson, MS 39205-0925 or you may fax all completed forms to our **Toll Free Fax Number – (877) 365-9423**

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. A deposit slip is ***NOT*** acceptable.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS:
I authorize American Public Life Insurance 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: _____

PRINT NAME: _____ **DATE:** _____

SIGNED: _____

ATTACH VOIDED/CANCELLED CHECK

American Public Life Insurance Company
A member of the American Fidelity Group

American Public Life Insurance Company
Mail to: Claims Department
P.O. Box 925
Jackson, MS 39205-0925
Toll Free Phone: 1-800-256-8606
Toll Free Fax: 1-877-365-9423

EMPLOYER – INITIAL CLAIM FORM

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

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

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

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

PREMIUMS:

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

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

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

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

SALARY AT TIME OF DISABILITY:

Hourly: $_____ Weekly $_____ Monthly: $_____

Annually: $_____ $_____
W-2, previous calendar year Year-to-date, current calendar year

Date last worked? _____

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

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

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

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

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

Please provide the name and phone number of Workers' Compensation carrier:

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

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

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American Public Life Insurance Company
Mail to: Claims Department
P.O. Box 925
Jackson, MS 39205-0925
Toll Free Phone: 1-800-256-8606
Toll Free Fax: 1-877-365-9423

EMPLOYEE – INITIAL DISABILITY CLAIM FORM

Name:	SS #:	Date of Birth:	Policy/Certificate #:
Complete Mailing Address:	Complete Residence Address:	Telephone Number:	

Do you have dependents under age 18: Yes ☐ No ☐ If yes, please list dependents' names and dates of birth below:

1) Please list medical condition or injury causing disability:	2) If disability is the result of an accident, please explain where, when, and how accident happened:

3) Is your disability the result of your employment? Yes ☐ No ☐ If yes, please submit copy of Worker's 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 treating physician(s):

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

10) 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.

WARNING - 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 a loss is subject to criminal and civil penalties. **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 regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **DC**: 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. **KY**: Any person who knowingly and with 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. **MA**: 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. **MD**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **MN**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NJ**: Any person who knowingly files a statement of claim containing any 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**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is 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. **VA**: 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. **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. **ALL OTHER STATES**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature	**Print Insured's/Patient Name**	**Date Signed**

American Public Life Insurance Company

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American Public Life Insurance Company
Mail to: Claims Department
P.O. Box 925
Jackson, MS 39205-0925
Toll Free Phone: 1-800-256-8606
Toll Free Fax: 1-877-365-9423

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: _____ ICD-9 Code: _____

Diagnosis: _____ ICD-9 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: _____ LMP: _____

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

History: Was the patient referred to you? Yes ☐ No ☐ Unknown ☐ 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: _____

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:

Attending 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:	

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

American Public Life Insurance Company

A member of the American Fidelity Group

PO Box 925, Jackson MS 39205-0925 • Toll Free Fax (877) 365-9423 • Toll Free Telephone (800) 256-8606

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Public Life Insurance Company (APL) 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) pharmacies; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carriers. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome/AIDS Related Complex) 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 this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

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 or a delay of benefits. I understand that I may revoke this authorization at any time by writing to APL South Claims Department, PO Box 925, Jackson MS 39205-0925 or by calling, toll-free, 1-800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: action has been taken in reliance on the authorization; or the law provides 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 redisclosed and no longer protected by the 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.

Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

Date of Birth Date Signed

I certify this information is true and correct.

Relationship of Personal Representative to Patient _____

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

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

Certain products administered by American Public Life Insurance Company are underwritten by American Fidelity Assurance Company.

CLAUTH (09/09)

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