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 Public Life 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

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

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

REQUEST FOR CONTINUING DISABILITY BENEFITS - SUPPLEMENTAL

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.

EMPLOYEE – CONTINUING DISABILITY CLAIM FORM

Name:	SS #:	Date of Birth:	Policy/Certificate #:

Complete Mailing Address:	Complete Residence 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.

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**

PHYSICIAN – CONTINUING 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:

Treatment: Is patient still under your care? Yes ☐ No ☐ If yes, 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: _____

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 clerical/administrative sedentary 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: _____

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. Your will be asked periodically for updates related to the individual's disability and treatment plan.