

FAX TO 1.866.887.6644

Questions? Call 1.800.325.4368 • 24 Hours A Day/7 Days a Week

OR YOU MAY MAIL TO:

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

Attn.: DISABILITY BENEFITS

P. O. BOX 100195

COLUMBIA, SOUTH CAROLINA 29202-3195



Making benefits count.

SECTION 1 TO BE COMPLETED BY POLICYOWNER

1. Policyowner name	Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	If the address given at left has changed since your last claim please mark box with an "x". <input type="checkbox"/>	
Address (Street Required for Overnight)			Policy Number	
City	State	Zip Code	Social Security Number	Birthdate (MM/DD/YYYY)
Policyowner Email Address				
2. Claim is for: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness			Home Telephone ()	Work Telephone ()
3. Date and Description of Injury/Sickness			Were you at work at the time of your injury/sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. List dates (MM/DD/YYYY) unable to work From: To:			If not employed, list dates (MM/DD/YYYY) of house confinement*: From: To:	
5. Have you returned to your place of employment? <input type="checkbox"/> Yes, <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time			Date Returned to Work (MM/DD/YYYY)	*house confinement means unable to do normal daily activities
6. List all doctors who have treated you for this condition and include your primary care physician's name first.				
Doctor's name		Phone Number	Address	
1.				
2.				
3.				
4.				

SECTION 2 TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

7. Dates (MM/DD/YYYY) Employee unable to work From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date Employee returned to his/her primary duties Date MM/DD/YYYY) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Light Duty		
8. Employee's Job Title		Employee's Salary	Monthly	Hourly
Employee's duties include:				
Lifting	<input type="checkbox"/> less than 15 lbs.	<input type="checkbox"/> 15 to 44 lbs.	<input type="checkbox"/> over 45 lbs.	
Stooping/bending	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent	
Crawling/climbing/kneeling	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent	
Reaching/pulling/pushing	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent	
Repetitive	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent	
Management duties	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent	
Sitting (Number of hours each day): _____				
Standing/Walking (hours each day): _____				
9. If injured, did the loss occur while the employee was at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date _____.				
10. Signed by _____		Title _____		
Date (MM/DD/YYYY) _____		Employer's Telephone Number () _____		
Employer's Email Address _____		Employer's Fax Number () _____		

SECTION 3 TO BE COMPLETED BY PHYSICIAN

11. What is this patient's current primary disabling condition? _____

Symptoms: _____ Objective Findings: _____

If pregnancy, what is the EDC? _____

Is condition due to an accidental injury? Yes No

If yes, describe the accident. _____

12. Are there secondary conditions contributing to the disability?

 Yes No

If yes, what are they and would the patient be disabled without regards to these secondary conditions?

13. List any test(s) or surgeries performed and submit a copy of the results.

14. Restrictions (What the patient SHOULD NOT do)

15. Limitations (What the patient CANNOT do)

16. How soon do you expect significant improvement in the patient's medical condition?

 1-2 months 3-4 months 5-6 months more than 6 months17. Is this patient permanently disabled? Yes No18. Is patient considered to be house confined and/or unable to perform 2 out of 5 activities of daily living*? Yes No
**Dressing, eating, transferring, toileting and meal preparation.*

List dates (MM/DD/YYYY) of house confinement.* From: _____ To: _____

**House confinement means unable to do normal daily activities.*

19. Dates of Total Disability (MM/DD/YYYY) From: _____ To: _____

Dates of Partial Disability (MM/DD/YYYY) From: _____ To: _____

Patient's expected return to work date (MM/DD/YYYY) _____

20. List All Office Visit Dates:

List All Hospitalization Dates:

21. Is patient currently being treated by any other practitioner or therapist? If so, list name and address.

Name and Address of Hospital

22. Signature of Physician or Supplier Date (MM/DD/YYYY)

Physician's supplier and group name

Telephone Number

Tax ID or SSN

Address

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23. Fax Number

Patient Acct. Number

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PLEASE SIGN AND RETURN THE AUTHORIZATION (ON REVERSE SIDE) AND CERTIFICATION BELOW TO AVOID DELAY.**CERTIFICATION**

Policyholder/Employee's Name _____ Social Security Number _____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the "Claim Fraud Warning and State Versions" form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. 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.

_____/_____/_____
Date(MM/DD/YYYY)_____
PATIENT SIGNATURE

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POLICYHOLDER/EMPLOYEE SIGNATURE