



Attention: Claims Department
 P.O. Box 1650
 Little Rock, Arkansas 72203-1650
 Telephone (501) 375-7200 Fax (501) 399-3806

Statement of Claim Short Term Disability Income Benefits

For H.O. Use Only	
Eff	
PTD	
Benefits	

Instructions

1. Please make sure all questions on Employee's Statement are completed in full.
2. Authorization must be signed and currently dated.
3. Employer's & Physician's Statements on Page 2 (reverse side) must be completed.
4. Mail the completed claim form to USABLE Life. If faxing the completed claim form, the original must also be mailed.

EMPLOYEE'S STATEMENT

Full Name (Last, First)		Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		Date of Birth	Occupation
City, State, Zip Code		Telephone Numbers	Home () Work ()
Claim is for <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy		Nature of Accident or Sickness	
Date of 1st Treatment	Physician or Hospital First Treated By		First Full Day of Disability
If accident, how did the accident occur? _____			
Accident Date _____ Time _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Place _____			
Names and addresses of all doctors consulted for this condition (Use separate sheet if necessary):			
Physician	Date Treated/Consulted	Address, City, State and Zip Code	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Have you ever had this or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give particulars: Date _____			
Describe _____			
Names and addresses of all doctors seen for any condition in the past five years (Use separate sheet if necessary):			
Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Authorization to Obtain Information			
<p>I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state, or local), Social Security Administration, or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USABLE Life (or its representatives) and to permit them to examine and copy any such information. I understand that USABLE Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company. A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge I have a right to a copy of this authorization upon request.</p> <p>WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.</p>			
Date _____		Employee's Signature _____	

Please have your Employer and Attending Physician complete page 2 (reverse side).

ATTENDING PHYSICIAN'S STATEMENT (APS)

**** Neither the Employee nor the Employer should complete or alter any part of the APS. ****

Patient's Full Name	Date of Birth
Diagnosis & Concurrent Conditions 1. _____ 2. _____	ICD Codes 1. _____ 2. _____
Disability is due to <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy If accident, provide how, when and where accident occurred _____ _____ _____ If Pregnancy, _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated Delivery Date _____ Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section _____ Date Symptoms First Appeared _____ Date Patient First Consulted You _____ Dates & Surgical Procedures (if any) _____ _____ If hospitalized, <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Admitted _____ Date Discharged _____ Full Name of Hospital _____ Address _____ City, State, Zip Code _____ Telephone # of Hospital _____	Did disability arise from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ How long was or will patient be unable to work due to disability? From _____ Through _____ Can return to work on _____ Please list all treatment dates during the month in which the disability began _____ _____ Date of next doctor's appointment _____ _____ List Restrictions and Limitations _____ _____ _____ Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ Describe any circumstances causing disability to be prolonged: _____ _____ _____

Physician's Signature	Provider Tax ID #	Date
Physician's Name (Please Print/Type)		Degree
Address		Telephone ()
City	State	Zip Code
		Fax ()

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EMPLOYER'S STATEMENT

Group Policy Number	Employee Social Security No.	Date of Hire	Coverage Effective Date	Weekly STD Benefit \$
Last Day Worked Date _____ # of Hours _____	Date Returned to Work: <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____	Base Salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	Employee Regularly Works _____ Hours Per Week Employee Regularly Works Weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Employee received: Salary continuation through _____ Vacation pay through _____ Sick pay through _____				
Employer Name			Tax ID #	
Signature		Title	Date	
Name (Please print or Type)		Telephone ()	Fax ()	
Street Address		City	State	Zip Code