300 Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
Fax: (207) 766-3448

Educator Disability Plan
Instructions for Filing Claims

Dear Insured:

USAble Life is pleased to provide you coverage when you are unable to work due to a covered disability. We have included these instructions and the necessary forms to assist you in the event you need to file a claim for disability benefits. Please remember that all forms must be received within 90 days of the date you stop work.

Employee Statement

1. Complete the Employee Statement in full.
2. Answer all questions or state “not applicable”.
3. Review the attached Fraud Statement as it applies to your state of residence, sign and date.
4. Sign and date the Authorization form.

Employer & Attending Physician Statements

1. Obtain the statement of your Attending Physician who will certify your disability.
2. Obtain the statement of your Employer.

Return All Forms to USAble Life:

Facsimile: (207) 766-3448

Mail: 300 Southborough Drive, Suite 200, South Portland, ME 04106

For Questions or Assistance Call or Contact USAble Life:

Telephone: (877) 254-0085

Attention: Claims Department
300 Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
Fax: (207) 766-3448

Statement of Claim
Educator Disability Plan
Income Benefits
Employee's Statement

Instructions

1. **Please type or print in blue or black ink.**
2. **Please make sure all questions on Employee's Statement are completed in full.**
3. **Employer's and Physician's Statements must be completed.**
4. **Authorization and Fraud Notice must be signed and currently dated.**
5. **Email, fax or mail the completed form to USAble Life.**

EMPLOYEE'S STATEMENT

Full Name (First, Middle, Last)	Social Security Number	Gender ☐ Male ☐ Female
Street Address	Date of Birth	Occupation
City, State, Zip	Telephone Numbers Home Work	
Claim is for ☐ Accident ☐ Sickness ☐ 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 ______ ☐ A. M. ☐ P.M. Place ______

Was a third party responsible for accident? ☐ Yes ☐ No If Yes, third party's name ______

Third party's address ______

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement) ☐ Yes ☐ No $_____ Mo. V.A. Benefits: ☐ Yes ☐ No $_____ Mo.
Dependent Social Security: ☐ Yes ☐ No $_____ Mo. Worker's Compensation: ☐ Yes ☐ No $_____ Wk.
Retirement: (normal, early or disability) ☐ Yes ☐ No $_____ Mo. Other Disability Coverage: ☐ Yes ☐ No $_____ Wk.
Unemployment: ☐ Yes ☐ No $_____ Wk. (identify)______

Include a copy of your award or denial letter for any source in which one has been received.

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? ☐ Yes ☐ 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

USAble Life

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Statement of Claim
Educator Disability Plan
Income Benefits
Attending Physician's Statement

Instructions

1. **Physician certifying disability must complete all questions, sign and date this Attending Physician's Statement.**
2. **Fax or mail the completed form to USAble Life.**

ATTENDING PHYSICIAN'S STATEMENT

Neither the Employee nor the Employer should complete or alter any part of this statement.

Patient's Full Name (First, Middle, Last)	Date of Birth
Diagnosis & Concurrent Conditions 1. 2.	ICD Codes 1. 2.

Disability is due to

☐ Accident ☐ Sickness ☐ Pregnancy

If accident, provide how, when and where accident occurred ______________

If Pregnancy, ______________ (Delivery Date) ☐ Actual ☐ Estimated

Date of LMP ______________

Type of Delivery ☐ Vaginal ☐ C-section

Date Symptoms First Appeared ______________

Date Patient First Consulted You ______________

Dates & Surgical Procedures (if any) ______________

If hospitalized, ☐ Inpatient ☐ Outpatient

Date Admitted ______________ Date Discharged ______________

Full Name of Hospital ______________

Address ______________

City, State, Zip Code ______________

Telephone # of Hospital ______________

Is Disability due to injury or sickness arising out of or in the course of patient's employment? ☐ Yes ☐ 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?

☐ No ☐ Yes Date ______________

Describe any circumstances causing disability to be prolonged:

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

FRAUD WARNING: Except as noted in the Fraud Notice, 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.

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300 Southborough Drive, Suite 200
South Portland, ME 04106
Telephone: (877) 254-0085
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Statement of Claim
Educator Disability Plan
Income Benefits
Employer's Statement

Instructions

1. **Employer must complete all questions, sign and date this Employer's Statement.**
2. **Fax or mail the completed form to USAble Life.**

EMPLOYER'S STATEMENT

Employee Name (First, Middle, Last)	Date of Birth	Social Security Number

Group Policy Number	Date of Hire	Coverage Effective Date	Monthly LTD Benefit $

Last Day Worked	Date Returned to Work	Base Salary $ ____________
Date _____________	☐ Full-Time ____________	☐ Hourly ☐ Weekly
# of Hours __________	☐ Part-Time____________	☐ Monthly ☐ Annually

Employee Regularly Works ________ Hours Per Week	Employee's Occupation

Check Days Normally Worked?	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat

If on rotation, give number of days worked per week: _______________

Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? ☐ Yes ☐ No

If yes, Status of claim? ☐ Pending ☐ Approved ☐ Denied ☐ Denial on Appeal

Name of Worker's Compensation Carrier: ____

Address of Worker's Compensation Carrier: ____

____

Employee received: Salary continuation through ____________ Vacation pay through ______________ Sick pay through ________________

Employer Name	Email address	Tax ID #
Signature	**Title**	**Date**
Name (Please print or Type)	**Telephone**	**Fax**

Street Address	City	State	Zip Code

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USAble Life

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

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. Please see below for special notices required by state law.

AL Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: 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 Residents Only: 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.

DE, ID, IN, OK Residents Only: 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 is guilty of a felony.

DC Residents Only: Warning: 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 Residents Only: 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 is guilty of a felony of the third degree.

KS Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

KY Residents Only: 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 and TN Residents Only: 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 and denial of insurance benefits.

MD, RI, TX Residents Only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH Residents Only: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ Residents Only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OH Residents Only: Any person who, with the 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.

OR Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison.

PA Residents Only: 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.

VT Resident Only: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

VA and WA Residents Only: 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.

______________________ ______________________

Date **Signature**