***Please return this completed packet to the employee or to LRSD Human Resources Department / fax: 501- 447-1162 to be processed as a completed claim packet.***

USAble Life
Live life. You're covered.℠

PO Box 1650
Little Rock, AR 72203-1650

# Short Term Disability 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 short term 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:**

**Email:** claims@usablelife.com

**Facsimile:** (501) 235-8417

**Mail:** PO Box 1650, Little Rock, AR 72203-1650

**For Questions or Assistance Call or Contact USAble Life:**

**Telephone:** (800) 370-5856 **Email:** claims@usablelife.com

USAble Life

# Little Rock School District
# Statement of Claim Short Term Disability

**INSTRUCTIONS FOR FILING CLAIMS**

1. **FIRST, HAVE YOUR EMPLOYER COMPLETE EMPLOYER'S STATEMENT.**
2. **EMPLOYEE SHOULD COMPLETE ALL ITEMS ON THE EMPLOYEE'S STATEMENT. IT MUST BE SIGNED AND CURRENTLY DATED.**
3. **HAVE YOUR PHYSICIAN COMPLETE THE PHYSICIAN STATEMENT ON PAGE 2/REVERSE AND RETURN TO: USABLE LIFE - CLAIMS DEPARTMENT - PO BOX 1650 - LITTLE ROCK, AR 72203-1650**

## PART 1 - EMPLOYER'S STATEMENT

| Employee's Full Name (Last, First) | School/Site of Employee | Phone Number of School/Site |
|---|---|---|
| | | 501-447-1101 |

| Group Policy Number | Plan No. | Annual Salary | Contract Days |
|---|---|---|---|
| **50033330** | | | |

| Date of Hire | Last Day Worked | No. of Hours Worked | Date Returned to Work |
|---|---|---|---|
| | | | UNKNOWN |

Is Employee eligible for Worker's Compensation? ☒ No ☐ Yes Amount $_____ per Week

**FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.**

| Employer **Little Rock School District** | Telephone ( **501**) **447-1100** |
|---|---|
| Signature | Title HR Benefits |
| Name (Please Print or Type) Marcela Copley | Date |

Address, City, State, ZIP **810 West Markham Little Rock, AR 72201**

## PART 2 - EMPLOYEE'S STATEMENT

| Full Name (Last, First) | Social Security Number |
|---|---|
| Street Address | City, State, Zip |

| Sex ☐ Male ☐ Female | Date of Birth | Telephone Numbers Home Work |
|---|---|---|
| Claim is for: ☐ Illness ☐ Accident | | Occupation |

| Date of 1st Treatment | Nature of Illness or Injury | First Full Day of Disability |
|---|---|---|
| | | |

Accident Date _____ Time _____ ☐ A.M. ☐ P.M. Place _____

How did the accident happen? _____

Names and addresses of all doctors consulted for **this** condition (Use separate sheet if necessary):

| Physician | Address, City, State and ZIP |
|---|---|
| | |
| | |

### Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge that I have a right to a copy of this authorization upon request.

**FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.**

**Date:** _____ **Employee's Signature** _____

**FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.**

## PART 3 - ATTENDING PHYSICIAN'S STATEMENT
## (Please Answer All Questions.)

Patient's Full Name (Last, First) | Date of Birth

Diagnosis & Concurrent Conditions | Include ICD Code

Disability is due to ☐ Accident ☐ Sickness ☐ Pregnancy

If Pregnancy, estimated delivery date _____

Date Symptoms First Appeared _____

Date Patient First Consulted You _____

If hospitalized: ☐ Inpatient ☐ Outpatient

Admission Date _____ Discharge Date _____

Hospital Name _____

Address _____

City, State, ZIP _____

Did disability arise from patient's employment?
☐ Yes ☐ No

How long was or will patient be disabled/unable to work?
From _____ Through _____

Can return to work on _____

Please list all treatment dates during the month in which disability began.

_____

_____

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 | Degree

Address

City | State | Zip

Telephone | Fax

**Return to:**

**USAble Life**
**Claims Department**
**PO Box 1650**
**Little Rock, AR 72203-1650**
**Phone: (800) 370-5856**
**Fax: (501) 235-8417**

USAble Life

# FRAUD NOTICE

P.O. Box 1650 ·Little Rock, Arkansas 72203-1650

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

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

**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 loss is subject to criminal and civil penalties.

**AR, LA, MD, RI, and WV:** 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.

**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 respect to a settlement or award from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies to the extent required by applicable law.

**DE:** Any person knowingly and with the intent to injure, defraud or deactivate any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**DC: 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:** 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.

**HI:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**ID:** Any person knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**IN:** A person knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

**KY:** Any person who knowingly and with the 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.

**MN:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

**NJ:** Any person who knowingly files a statement of claim containing 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:** A 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 false or deceptive statement is guilty of insurance fraud.

**OK: WARNING:** any person who knowingly and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OR:** A person who knowingly and with the intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be 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.

**TN, VA and 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.

**TX:** 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.

Date _____ Signature _____

USAble Life

P.O. Box 1650
Little Rock, AR 72203-1650

# Authorization to Disclose, Obtain and Use Personal Information

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the Medical Information Bureau, benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

I have executed this authorization intending that it will be effective on and after

_____
(Date)

_____ _____
Signature Printed Name

Return original with your claim & retain a copy of this authorization and claim form for your records.