# Claim Form and Instructions for Group Short Term Disability Employer

## Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing the employee's request for benefits.**

Completed form should be sent directly to UnitedHealthcare Specialty Benefits:

**Mail:**
UnitedHealthcare Specialty Benefits
PO Box 31328
Salt Lake City, UT 84131-0321

**Email** (email is unsecured unless you are a registered Cisco user):
FPCustomerSupport@uhc.com

**Fax:**
888-505-8550

**Phone:**
888-299-2070

## Claim filed for

| Employee's Name (first, middle initial, last) | | Employee's Social Security Number |
|---|---|---|
| Employee's Street Address, City, State, ZIP Code | | |
| Employee's Phone Number | Employee's Date of Birth | Employer's Work State |

| Employer's Name (Parent Company/Policyholder) | Group STD Policy Number | Employer's Phone Number |
|---|---|---|
| Employer's Address, City, State, ZIP Code | | |

TO BE COMPLETED BY EMPLOYER

## Employment and Claim Information

| Date of hire | Last day worked (physically)? Hours worked last day? | Division/Class |
|---|---|---|
| | | |

| Occupation (attach formal job description) | List employee's job duties |
|---|---|
| | |

**Physical Job Demands**

Job Demand (answer each item below)

| | | | | |
|---|---|---|---|---|
| Sitting | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Standing | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Walking | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Balancing | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Kneeling | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Stooping/Crouching | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Crawling | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Climbing | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Overhead Reaching | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Typing | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Lifting/Carrying – up to pounds | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |
| Pushing/Pulling – up to pounds | ◯ Continuously | ◯ Frequently | ◯ Occasionally | ◯ Not Performed |

Has employment been terminated? ◯ Y ◯ N If yes, termination date?

Has employee returned to work? ◯ Y ◯ N If yes, return to work date?

Employee has returned to work in what capacity? ◯ Full Time ◯ Part Time (attach payroll records)

Are you willing to make return-to-work accommodations for the employee if needed? ◯ Y ◯ N

Was employee injured at work? ◯ Y ◯ N If yes, date of injury?

If yes, was Worker's Compensation filed? ◯ Y ◯ N

Please send in first injury report.

TO BE COMPLETED BY EMPLOYER

## Benefits and Earnings Information

Does the employee contribute to the STD premium? ◯ Y ◯ N (If yes, please provide a copy of enrollment form)

If yes, does s/he contribute on a PRE or POST tax basis? ◯ Pre Tax ◯ Post Tax

What percentage does s/he contribute to their STD premium? %

Is the employee also covered under a LTD or Life Insurance Policy provided by us? ☐ LTD ☐ Life

If yes, do they contribute to the LTD premium? ◯ Y ◯ N

If yes, do they contribute on a PRE or POST tax basis? ☐ Pre Tax ☐ Post Tax and Percentage %

| How is the employee paid? | Does the employee receive other work related income? |
|---|---|
| Hourly $ (Per Hour) | Commissions $ |
| Hours worked per week | Bonuses $ |
| Salaried $ (Annually) | Overtime $ |

Does the employee receive any of the following:

| Source of Income | Benefit Amount | Weekly or Monthly Benefit | Benefit Coverage Dates (MM/DD/YY) |
|---|---|---|---|
| Salary Continuance | $ | ☐ Wkly ☐ Mthly | From: Through: |
| State Disability | $ | ☐ Wkly ☐ Mthly | From: Through: |
| Sick Pay | $ | ☐ Wkly ☐ Mthly | From: Through: |

## Final Signature and Certification

| | |
|---|---|
| Name of Human Resources Contact completing this form | Human Resources E-mail address |
| Human Resources Title | Human Resources Phone number Ext |
| Human Resources Contact Signature (eSignature is allowed) | Date Signed by Human Resources Contact |

*Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:*

**Fax:** 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com

**Mail:** PO Box 31328 Salt Lake City, UT 84131-0321

# Claim Form and Instructions for Group Short Term Disability Employee

**Instructions**

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing your request for benefits.**

Completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits:

**Mail:**
UnitedHealthcare Specialty Benefits
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Salt Lake City, UT 84131-0321

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FPCustomerSupport@uhc.com

**Fax:**
888-505-8550

**Phone:**
888-299-2070

**General Demographics**

| | | |
|---|---|---|
| Employee's Full Name (first, middle initial, last) | | Employee's Social Security Number |
| Employee's Street Address, City, State, ZIP Code | | |
| Employee's Phone Number | Employee's Date of Birth | Preferred Pronoun(s) |
| Employee's Marital Status ◯ Single ◯ Married<br>If married, Spouse's First and Last Name | | |
| Do you authorize UHC to communicate with you via email? ◯ Yes ◯ No<br>If yes, what is your email address? | | |

| | |
|---|---|
| Employer's Name (include division if applicable) | Employer's Phone Number |

TO BE COMPLETED BY EMPLOYEE

## Employment and Claim Information

| Date you first noticed symptoms of illness/injury | When were you first treated for your injury or illness? |
|---|---|

Please confirm your condition and symptoms that prevents you from working

Is your claim a result of: ◯ Illness ◯ Accident ◯ Surgery

If accident, please provide the date and type of accident: Date Type

Was your injury or illness due to an auto accident? ◯ Y ◯ N

If yes, provide auto carrier name/address/phone number

If yes, have you filed an auto insurance claim? ◯ Y ◯ N

| Were you injured at work? ◯ Y ◯ N<br>If yes, date of injury<br>Was Workers' Compensation claim filed? ◯ Y ◯ N | If surgery,<br>The date of surgery<br>Type of surgery |
|---|---|

Please provide the contact information for the physician(s) that first advised you to stop working due to your current medical condition. If more space is needed, please attach additional paper.

| **Physician Name** | Office Phone #<br>Office Fax # | Physician's Address | |
|---|---|---|---|
| Specialty | Date First Seen | Date Last Seen | Currently Treating? ◯ Y ◯ N |
| **Physician Name** | Office Phone #<br>Office Fax # | Physician's Address | |
| Specialty | Date First Seen | Date Last Seen | Currently Treating? ◯ Y ◯ N |

## Benefits and Earnings Information

Are you receiving/ have you applied for any of the following benefits (include benefits for you or any family member)? Please provide copies of any decisions, including denial and/or award notices for any benefits noted below.

| *Type of Benefit* | *Applied for or appealed? State if pending* | *Benefit Amount* | *Payment Frequency* | *Benefit Coverage Dates (MM/DD/YY)* |
|---|---|---|---|---|
| Social Security Disability /Retirement | | $ | ☐ Wkly ☐ Mthly | From: Through: |
| State Disability | | $ | ☐ Wkly ☐ Mthly | From: Through: |
| Auto No Fault | | $ | ☐ Wkly ☐ Mthly | From: Through: |

## Tax Information

| | |
|---|---|
| If your request for benefits is approved, do you want the minimum $20.00 per week withheld from your check for Federal Income Tax purposes?<br>◯ Y ◯ N | If you would like more than $20.00 withheld per week, please state the whole dollar amount you want withheld weekly.<br>Amount $<br>(minimum amount per week is $20.00) |

## Final Signature and Certification

*The above statements are true and complete to the best of my knowledge and belief.*

*I acknowledge that I have read the applicable Fraud Warning Notice provided with this claim form.*

| | |
|---|---|
| Name of person completing this form | Phone Number |
| Signature<br>(eSignature is allowed) | Date Signed |

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**Mail:** PO Box 31328 Salt Lake City, UT 84131-0321

**DISCLOSURE AUTHORIZATION** **TO BE COMPLETED BY EMPLOYEE**

Participant's Name (Please Print):_____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 12 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

**PLEASE SIGN AND DATE IN INK**

Relationship, if other than Claimant: _____

*Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:*

**Fax:** 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com

**Mail:** PO Box 31328 Salt Lake City, UT 84131-0321

(Rev. 06/18)

**AUTHORIZATION OF PERSONAL REPRESENTATIVE** **TO BE COMPLETED BY EMPLOYEE**

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my disability claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

**Date:**

**Signature:** _____

**PLEASE SIGN AND DATE IN INK**

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UnitedHealthcare

**ATTENDING PHYSICIAN'S DISABILITY STATEMENT** **TO BE COMPLETED (for employee) BY PHYSICIAN**

Legible completion of this form is requested to ensure prompt service to your patient.

1. Patient's Name (first, middle initial, last)

2. Date of Birth Height Weight

3. Diagnosis & ICD10 code (include complications)

4. Did the patient have surgery? ◯ Yes ◯ No
If yes, what is the CPT code?

5. Date you advised patient to stop working?

6. Is condition due to or exacerbated by injury/ sickness arising out of patient's employment? ◯ Yes ◯ No ◯ Unknown

7. Date of first visit for this illness

8. Date of last visit

9. Diagnosis & ICD10 code (include complications)

10. If pregnancy, expected delivery date

11. If delivered, actual delivery date

12. ◯ Vaginal delivery
◯ C - Section

13. Was patient hospitalized? ◯ Yes ◯ No

14. Name & address of hospital

15. Date Admitted

16. Date Discharged

17. What are your patients symptoms? Describe your examinations findings. Please feel free to attach any medical records

18. In an 8-hour workday, the patient can perform: (Circle of check number of hours):

Sit for ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 hours at a time

Stand ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 hours at a time

Walk ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 hours at a time

Drive ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 hours at a time

Patient is able to lift/carry up to pounds frequently, and up to pounds occasionally

Patient is able to push/pull up to pounds frequently, and up to pounds occasionally

Patient can perform fingering/keyboarding: ◯ Frequently ◯ Occasionally ◯ Rarely

Patient can perform handling: ◯ Frequently ◯ Occasionally ◯ Rarely

Patient can perform grasping: ◯ Frequently ◯ Occasionally ◯ Rarely

19. Expected Return to Work Date

20. Can patient resume full duties upon return to work? ◯ Yes ◯ No
If no, please explain?

21. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ◯ Yes ◯ No

**Signature of Attending Physician – next page**

**Signature of Attending Physician**

| | | |
|---|---|---|
| *The above statements are true and complete to the best of my knowledge and belief.*<br>*I acknowledge that I have completed this form in its entirety.* | | |
| Physician's Name | Degree & Specialty | NPI Number |
| Physician's Office Street Address | Physician's Office Phone Number | Physician's Office Fax Number |
| Are you related to this patient? ◯ Y ◯ N If yes, what is the relationship? | | |
| **Physician's Signature**<br>(eSignature is allowed) | | Date Signed by Physician |

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**Mail:** PO Box 31328 Salt Lake City, UT 84131-0321

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For claimants in Alabama:**
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.

**For claimants in Alaska:**
A 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.

**For claimants in Arizona**:
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.

**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.**

**For claimants in Colorado:**
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.

**For claimants in Connecticut:**
Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

**For claimants in Delaware**:
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.

**For claimants in District of Columbia:**
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.

**For claimants in Florida:**
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

**For claimants in Hawaii:**
**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.**

**For claimants in Idaho**:
Any person who knowingly, and with 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.

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

**For claimants in Kansas:**
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 may be guilty of fraud as determined by a court of law.

**For claimants in Kentucky:**
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.

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For claimants in Maine:**
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.

**For claimants in Maryland:**
Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

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

**For claimants in New Hampshire:**
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.

**For claimants in New Jersey:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**For claimants in New Mexico:**
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 penalties.

**For claimants in Ohio:**
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.

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

**For claimants in Oregon**:
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 may be subject to fines and confinement in prison.

**For claimants in Pennsylvania:**
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.

**For claimants in Tennessee and Washington:**
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.

**For claimants in Texas:**
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.

**For claimants in Vermont:**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

**For claimants in Virginia:**
Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may have violated state law.

**For claimants in All Other States:**
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.

PO Box 31328 Salt Lake City, UT 84131-0321
Tel 888 299 2070
Fax 888 505 8550

# Claims Department
# Direct Deposit Agreement
# For Payment of Benefit to Financial Institution

## Section 1 (to be completed by benefit recipient)

Name of Benefit Recipient

UHCSB Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

## Section 2

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account ☐ Checking ☐ Savings (check one)

**Attaching a Voided Blank Check will Expedite Processing Your Claim**