



Statement of Short Term Disability

Claim Filing Instructions

This Statement of Short Term Disability (STD) includes the forms required to apply for STD benefits. **If a form is received incomplete, unsigned or undated, it will be returned to you for completion, delaying the claim.**

Have you...

- 1) Completed the **Employee's Statement**?
 - a) Incomplete, unsigned, or undated statements will delay your claim
- 2) Signed and dated the **Authorization for Release of Information**?
- 3) Had the physician treating you sign and date the **Attending Physician's Statement**?
 - a) The Attending Physician's Statement must be returned to you upon completion
- 4) Had your Employer sign and date the **Employer's Statement**?
 - a) The Employer's Statement must be returned to you upon completion

You are responsible for ensuring all forms are completed and returned to our office. Our review of your claim will not begin until we receive all completed forms.

Forms can be sent to LifeMap via:

Email: **claims@lifemapco.com**
Fax: **1 (855) 733-4615**
Regular Mail: **LifeMap Assurance Company**
Attn: Life and Disability Claims Department
200 SW Market Street, Suite 800
Portland, OR 97201

You must notify LifeMap promptly if:

- Your medical condition improves so you would be able to work, even if you have not yet returned to work.
- You go to work in any capacity for any employer, even as a self-employed person.
- You receive any other income related to your disability.

If you have any questions, please call the LifeMap Life and Disability Claims Department at 1 (800) 286-1129.

Direct Deposit Option

If you are approved for benefits, you will receive a weekly benefit payment. Payments are sent via paper check by U.S. mail; however, you can elect electronic direct deposit. To establish electronic direct deposit, fill out the optional **Direct Deposit form** (enclosed) and return along with a voided check to our office.

Paper checks will be issued unless a direct deposit election is received and processed prior to benefit issuance. Allow a week for LifeMap to process your direct deposit election. To expedite the processing of your election, please submit your signed and dated form with voided check by fax to the number listed above or email: claims@lifemapco.com.



Statement of Short Term Disability

Employee's Statement

Employee

Employee Name (Last, First, Middle Initial)			Social Security Number		
Mailing Address	Street & Number	City	State	Zip	
Home Phone Number	Cell Phone Number	Email Address	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Employment

Employer Name	Employer Phone Number	Group Policy Number
Date you returned (or expect to return) to work on a part-time basis:	Date you returned (or expect to return) to work on a full-time basis:	
Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____		

Medical Information

Date First Treated:	First date unable to work because of disability:	
Date of injury or date first noticed symptoms of illness:	Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when	
Is your injury or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Did you file for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Yet	Workers' Compensation claim status: <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Denied (include copy of denial letter)
Cause of Disability: <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy	Please explain illness or accident (include date and location):	

Attending Physician

Primary Physician:	Phone Number	Hospital	
Street Address	City	State	Zip
Fax Number		Date Admitted	Date Discharged

Other Sources of Income

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

Type	\$ Amount (per week)	Date Began	Date Ended	Type	\$ Amount (per week)	Date Began	Date Ended
Social Security (SSA)				Pension			
SSA Dependent's				State Disability / State Leave			
Workers' Compensation				Other (describe):			

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

► _____ ► _____
Employee's Signature Date

Please complete Authorization to Obtain and Release Information form on page 4.

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Insurance Fraud Warning

Unless specific state language is provided below, the following fraud notice applies: 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.

Arizona Residents: 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.

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Colorado Residents: 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.

District of Columbia Residents: 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.

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Hawaii Residents: 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.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: 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.

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

New York Residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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Delaware, Idaho, Indiana and Oklahoma Residents: 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.



Statement of Short Term Disability

Authorization to Obtain and Release Information

I authorize persons or entities having any records or knowledge of me or my health, including any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer:

To give Medical information including chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results and prognosis with respect to any physical or mental condition and/or treatment of me, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records which may have been acquired in the course of examination or treatment.

If the information to be disclosed contains any of the types or information listed below, additional laws relating to the use and disclosure may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information:

- _____ Drugs/Alcohol diagnosis, treatment or referral information
- _____ Mental Health information – including provider notes
- _____ HIV/AIDS information
- _____ Genetic Testing Information

And Non-medical information including education, employment history, earnings or finances, vocational evaluation reports, vocational testing and rehabilitation plans, or eligibility for other benefits including retirement benefits and retirement plan contributions (for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claim status, benefit amounts, effective dates, etc.).

To LifeMap Assurance Company (LifeMap) and to its authorized representatives.

- I understand that the information obtained by use of this authorization will be used by LifeMap and authorized representatives to evaluate and adjudicate my current disability claim and, in order to assist with the evaluation and adjudication of my current disability claim, may be re-disclosed to (a) my employer (for return to work and accommodation discussions, including dates of birth related to pregnancy claims for proper coordination of pay options and return to work dates); (b) any medical, investigative, financial or vocational specialist or entity, or (c) any other organization or person, employed by or representing LifeMap.
- I understand that LifeMap will release information to my employer necessary for return to work and accommodation discussions, and when performing administration for my employer's self-funded (and not insured) disability plans.
- I understand that LifeMap complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to LifeMap may be subject to redisclosure and may no longer be protected under the Health Information Portability and Accountability Act (HIPAA).
- I understand that: (a) I have the right to revoke this authorization by notifying LifeMap in writing, of my revocation; (b) my revocation will not be effective to the extent that a person or entity described above relied on the authorization to disclose information to LifeMap before being notified of my revocation; and (c) although no person or entity described above will condition treatment, payment, enrollment in or eligibility for benefits on me signing the authorization, my revocation of or failure to sign the authorization may affect LifeMap's evaluation of my current disability claim and may be a basis for denying my claim for such benefits.
- I acknowledge that I have read this authorization. I understand and agree that this authorization shall remain in force for the duration of my claim(s) or 12 months, whichever occurs first. A photocopy or facsimile of this authorization is as valid as the original. I understand that I, or my authorized representative, have the right to request and receive a copy of this authorization and the information to which it pertains.

Employee/Primary Insured's Full Name (please print clearly)	Social Security Number
Employee/Primary Insured's Signature	Date Signed

If signature is provided by legal representative (e.g. Attorney in Fact, guardian or conservator), please attach documentation of legal status.



Statement of Short Term Disability

Employer's or Administrator's Statement

Information about Employee

Employee Name (Last, First, Middle Initial)		Job Title	Social Security No	Class	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employee's Mailing Address Street & Number		City	State	Zip	Employee's Phone Number	
Date of Hire	Date Last Actively At Work Before Disability: (Attach payroll records for work activity since disability began)		hours worked that day:	Date of Termination: <input type="checkbox"/> N/A		
Reason for stopping work:		<input type="checkbox"/> Disability	<input type="checkbox"/> Dismissed	<input type="checkbox"/> Resigned	<input type="checkbox"/> Layoff	<input type="checkbox"/> Retired
<input type="checkbox"/> Family Medical Leave of Absence		<input type="checkbox"/> Other Leave of Absence	<input type="checkbox"/> Other Reason _____			
Date returned to work:		If part-time, number of hours worked per week:	If employee has not returned to work, estimated return to work date:			
Full-time: _____ Part-time: _____		_____ week:	_____			
Are you able to accommodate release to: If no, please explain:		Reduced hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	Modified duties? <input type="checkbox"/> Yes <input type="checkbox"/> No			
# of hours regularly scheduled per week:		Please indicate which days of the week this employee is normally scheduled to work. (circle) Sunday Monday Tuesday Wednesday Thursday Friday Saturday				
Please describe primary job duties:						
Employee's Earnings: \$			Is disability due to employment?			
Earnings prior to increase \$		Date of last increase:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
<input type="checkbox"/> hourly <input type="checkbox"/> weekly		<input type="checkbox"/> monthly <input type="checkbox"/> annual	Has Workers' Compensation claim been filed?			
<input type="checkbox"/> commission <input type="checkbox"/> shift differential		<input type="checkbox"/> bonuses <input type="checkbox"/> other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not yet			

Information about Employee's Short Term Disability Coverage

Employee's Short Term Disability Insurance:		What percentage of the STD premium does the Employer pay? _____%
Insurance Effective Date:	Insurance Termination Date:	Are employer paid premiums included in employee's salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
		Is employee contribution: <input type="checkbox"/> Pre-Tax Deduction <input type="checkbox"/> After-Tax Deduction <input type="checkbox"/> N/A

Other Benefits and Sources of Income

Income Employee is receiving or will receive following last day worked: <input type="checkbox"/> None							
Type	\$ Amount (per week)	Date Began	Date Ended	Type	\$ Amount (per week)	Date Began	Date Ended
Sick Pay				PTO / Vacation			
State Disability / Leave				Salary Continuation			
Workers' Compensation				Other (describe):			

Additional Documentation Attached (Please attach a copy of the following documents to this form.)

- Employee's current job description
- Employee's Workers' Compensation claim(s) and Approval/Denial Notification, if applicable

Information about Employer

Employer Name		Location Code (if applicable)		Group Policy Number	
Employer Address	Street & Number	City	State	Zip	Phone Number
Name and title of employer representative completing this form					Email Address

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

► _____ ► _____
 Employer Representative's Signature Date



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Statement of Short Term Disability

Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to insurance company.

Patient Information

Name of Patient (Last, First, Middle Initial)		Social Security Number	Employer Name	
Patient's Mailing Address		City	State	Zip
Patient's Phone Number				
Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Patient Dominant Arm: <input type="checkbox"/> Left-handed <input type="checkbox"/> Right-handed

Information about Diagnosis

Diagnosis	ICD Code(s)
Symptoms	
Comorbid Conditions	
Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings)	
Date symptoms first appeared or injury occurred:	Date you recommended the patient stop working on:
Patient's condition is due to: <input type="checkbox"/> Illness <input type="checkbox"/> Accident	Has patient ever had the same or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when
Is condition arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Information about Treatment

Date of first visit for this condition:	Date of most recent visit:	Frequency of subsequent visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	Next office visit:
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)			
Hospital Admission Date:	Hospital Discharge Date:	Was Surgery Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery:
Name of Procedure:		Surgery/Post-Operative Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	
Was patient treated by another provider(s) for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide dates, name and address of provider(s):			

For Pregnancy Disability Only

Date of Last Menstrual Period	Expected Date of Delivery	Actual Date of Delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
Are there any present complications or anticipated difficulties with: Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No Delivery <input type="checkbox"/> Yes <input type="checkbox"/> No Post Partum Recovery <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to any of these, please describe in detail:			

Continued on following page.



Statement of Short Term Disability

Attending Physician's Statement (continued)

Name of Patient (Last, First, Middle Initial)

Assessment of Current Functional Ability

Check the appropriate box indicating frequency your patient could perform the following activities:

	Occasionally, 0%-33%	Frequently, 33%-66%	Continuously, 66%-100%
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/pulling	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____
Lifting (lbs.)	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____	<input type="checkbox"/> No. of lbs. _____

What is this assessment based on? Observed activity Measured capacity Physical therapy report

Describe current restrictions (activities which should not be performed by the patient):

Describe current limitations (activities which cannot be performed by the patient):

Related to a mental health condition, describe behaviors, attitudes or functional impairments that are contributing to the patient's restrictions and/or limitations:

Describe factors delaying recovery (if applicable): Malingering Exaggeration Other, please specify:

Is the patient competent to manage insurance benefits? Yes No
If no, is the patient competent to appoint someone to help manage the insurance benefits? Yes No

Return to Work Plan

Date you released patient to return to work: Full Time Modified Duties Part Time Reduced Hours Number of hours per week:

How long do you expect these limitations and restrictions to impair your patient?
 Date _____ Unable to determine, follow up appointment on _____ Permanently

Please identify your recommendations for any job modifications that would enable the patient to work:

Information about Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number
Office Address	City State Zip	Fax Number

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 9 of this form.

Attending Physician's Signature Date

Please return completed form to your patient or fax to our office at 1-855-733-4615.

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200 SW Market Street, Suite 800
Portland, OR 97201

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free: 1 (800) 286-1129
Fax: (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Claim Benefits – Direct Deposit Option

We have enhanced our benefit payment system to enable us to send benefit payments by direct deposit to your checking account.

How do I sign up for direct deposit?

If you wish to receive your LifeMap benefit payments through direct deposit, you must complete this direct deposit authorization form and include a copy of a voided check for a checking account. *A deposit slip cannot be used for a checking account; you must provide a voided check.* Any authorizations submitted without the proper documentation will be returned to you without processing. The authorization must then be mailed, faxed, or emailed to LifeMap at the contact information shown above.

How will I know if my benefit payment has been processed if I am not getting a check in the mail?

With each benefit payment that is processed, you will receive, via mail, an explanation of the benefit payment showing the amount and date of the payment. In place of the check, a notification of deposit will be included with the explanation of benefit.

AUTHORIZATION FOR AUTOMATIC BENEFIT PAYMENT DEPOSITS

Claimant Information

Full Name of Employee (last, first, middle initial)	Social Security Number	Employer Name	Policy Number
Mailing Address (Street, City, State, Zip)			Phone Number

Information about Financial Institution

Financial Institution	Branch	Account Number	Routing Number
Mailing Address (Street, City, State, Zip)			Type of Account <input type="checkbox"/> Checking

Authorization

I wish to have my LifeMap benefit payment deposited directly to my checking account. I hereby authorize LifeMap to originate an electronic credit transaction to my bank or credit union account as indicated below and to credit the same to such account. In the event that a payment is credited to my account in error, I will be given written notice of the error. I hereby authorize LifeMap to deduct from my account for any payments credited to my account in error. In the event that a legal proceeding is filed in court to recover the amount of overpayment, the prevailing party shall also be entitled to an award of reasonable attorney fees and costs. This authority is to remain in full force and effect until I notify LifeMap in writing of my request to discontinue direct deposit and LifeMap will act upon this request within 5 business days following receipt of my request.

Signature _____ Date _____

For direct deposit account verification include a VOIDED CHECK for direct deposit

ATTACH HERE

(Please do not staple)

Note: Do not attach a deposit slip for a checking account.