

EssentialCare®

HOW TO FILE A CLAIM for SHORT-TERM DISABILITY

Claim payment may be delayed if information is incomplete or missing.

Part One (Page 1) – To be completed by the Employer. Please note that employer signature, date and employee's salary information are required.

Part Two (Page 2) – To be completed by Employee. Employee signature and date are required.

Part Three (Page 3) – To be completed by the Physician treating the employee for the illness/injury associated with the disability. Physician signature and date are required.

Checklist to make sure all information required has been enclosed:

_____ **Part One of the claim form is complete, signed and dated.**

_____ **Part Two of the claim form is complete, signed and dated.**

_____ **Part Three of the claim form is complete, signed and dated.**



Administered by Planned Administrators Inc.,
Columbia, South Carolina



Underwritten by BCS Insurance
Company, Oakbrook Terrace, Illinois

Disability Proof of Loss Form

Mail to: PAI, P.O. Box 6702, Columbia, SC 29260-6702

Claims payment may be delayed if information is incomplete or missing.

Part One: Employer Completes This Section

Employer's Name: _____ Policy Number: _____

Address: _____

Street

City, State

ZIP

Employer's Telephone: _____ Contact Person: _____ email: _____

Employee's Name: _____ SSN: _____

Last

First

Middle

Address: _____

Street

City, State

ZIP

Home Telephone: () _____ Birth Date: _____ Sex: Male Female

Date Hired: _____ Effective Date of Coverage: _____

Base Earnings: Mo \$ _____ Wkly \$ _____ Occupation: _____

Employee laid off prior to this illness? Yes No If yes, date: _____

Date employee first unable to work: _____ Date employee returned to work: _____

Was illness or injury due to patient's occupation? Yes No (If yes, explain.)

I hereby certify that the above named employee is a member of our group insurance program and the information stated above is correct to the best of my knowledge and belief.

Employer's Signature: _____

Title: _____

Date: _____



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Part Two: Employee Completes This Section

Employee's Name: _____ Birth Date: _____
Last First Middle

Date of First Treatment (Illness): _____ Date of Accident (Injury): _____

If accident, how did occur? _____

Did accident occur at work? Yes No Date first unable to work: ____ / ____ / ____

Did employee have same or similar condition in past? Yes No

If yes, when and list name and address of attending physician:

Remarks: _____

Authorization Instructions: The authorization should be completed and signed by the insured. If the insured is unable to work, the authorization should be completed and signed by the legal guardian or next-of-kin.

To all physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, the Social Security Administration, Blue Cross Blue Shield, self-insured and prepaid health plans):

You are authorized to permit Planned Administrators, Inc. and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, taxes, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus) and disease of:

PRINT NAME OF EMPLOYEE

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

Employee Signature

Date

(If signed by other than the Insured, please include guardianship papers or other evidence of legal representation.)

Legal Guardian Name

Relationship to insured

Address

Disability Proof of Loss Form



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Part Three: Attending Physician's Statement (Medical records attached? Yes No)

Patient's Name _____ Age _____
Last First Middle

Address: _____
Street City State ZIP

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT: SIGNED (PATIENT) : _____ DATE: _____

- 1) a. Diagnosis -ICD9 Code _____ and concurrent condition description _____
If Fracture or Dislocation, describe nature and location. _____
- b. Is condition due to injury or sickness arising out of patient's employment? Yes No (If "Yes" explain.) _____

- c. Is the condition pregnancy? Yes No (If "Yes" what was the approximate date of commencement of pregnancy?) Date: _____
Type of Delivery: _____

- 2) a. When did symptoms first appear or accident happen? Date: _____
- b. When did patient first consult you for this condition? Date: _____
- c. Has patient ever had same or similar condition? Yes No
If "Yes" state when and describe: _____

- 3) a. Nature of Surgical or Obstetrical Procedure, if any. _____
Date Performed: _____ Inpatient Outpatient
Describe fully and include current CPT-4 codes. _____

- b. If performed in a hospital, give name of hospital and dates hospitalized. _____

4) Give dates of other medical (Non-Surgical) treatment, if any. _____

5) Is patient still under your care for this condition? Yes No
If "No" give date your services terminated. Date: _____

- 6) a. How long was or will patient be continuously totally disabled? From-To Date: _____
If known, please estimate anticipated recovery date. _____

- b. Is this an extension of a previous disability claim? Yes No Previous date: _____
(If yes, provide new dates through which patient will be totally disabled.)

7) To your knowledge does patient have other Health Insurance or Health Plan Coverage? Yes No (If "Yes" identify) _____

Signature: _____ Date: _____

Physician's Name: _____ Degree: _____ Telephone: _____

Address: _____
Street City State ZIP

Individual practitioner's I.D. Number: _____

Fraud Statement



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Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties. The laws of some states require us to furnish you with the following notices: **WARNING. Any person who knowingly:**

Alaska: 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.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or 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, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** 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.

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

Ohio: 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.

Oklahoma: and with 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.

WARNING:

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.

District of Columbia, Tennessee and Virginia: It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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.

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

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.

