

Regence

Life and Health Insurance Company

Group Long Term Disability Claim Filing Instructions

Have you...

1. Completed the Employee's Statement in full?
2. Had the physician treating you complete the Attending Physician's Statement, and had it returned to you?
3. Had your Employer complete the Employer's Statement, and had it returned to you?
4. Read, signed and dated the Authorization for Release of Information?

Submit the completed statements to the address below.

**All portions of these forms must be completed
in order to expedite your claim.**

**If you have any questions when completing this form,
please call:**

**Toll-Free 1-(800) 794-5390, extension 5654
In Portland (503) 412-5654**

**Regence Life and Health Insurance Company
Attn: LTD Claims
PO Box 1271 MS E3A
Portland, OR 97207-1271**

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Life and Health Insurance Company

PO Box 1271 MS E3A
Portland, OR 97207-1271

Toll Free 1-(800) 794-5390, ext. 5654
Fax 1-(503) 220-3903

NOTICE OF CLAIM FOR LONG TERM DISABILITY BENEFITS

EMPLOYEE'S STATEMENT (TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

NAME OF EMPLOYEE		EMPLOYEE'S SOCIAL SECURITY #	
EMPLOYEE'S ADDRESS		STREET & NO.	CITY STATE ZIP
TELEPHONE NO. () -	DATE OF BIRTH / /		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/> RIGHT-HANDED <input type="checkbox"/> LEFT-HANDED	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DEPENDENT CHILDREN
LIST NAMES AND DATES OF BIRTH OF SPOUSE AND DEPENDENT CHILDREN			
HOW MANY HOURS WERE YOU REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER? _____ hrs.	GROSS ANNUAL SALARY (not including overtime) during the 12 months just prior to your disability - for this employer only \$ _____	PLEASE INDICATE HOW YOU ARE PAID (check all that apply): <input type="checkbox"/> hourly <input type="checkbox"/> salaried <input type="checkbox"/> other _____ <input type="checkbox"/> includes commissions? <input type="checkbox"/> includes bonuses?	
NAME OF EMPLOYER		EMPLOYER'S TELEPHONE NO. () -	
EMPLOYER'S ADDRESS		STREET & NO.	CITY STATE ZIP
YOUR OCCUPATION & TITLE	LIST ESSENTIAL DUTIES OF YOUR JOB AT THE TIME OF DISABILITY		
DATE OF INJURY OR DATE FIRST NOTICED SYMPTOMS OF SICKNESS / /	YOU HAVE BEEN UNABLE TO WORK BECAUSE OF DISABILITY SINCE: / /	YOU RETURNED TO WORK ON A PART-TIME BASIS ON: / /	YOU RETURNED TO WORK ON A FULL-TIME BASIS ON: / /
IS YOUR INJURY OR SICKNESS RELATED TO YOUR OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES", EXPLAIN: DID YOU FILE FOR WORKERS' COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DESCRIBE HOW AND WHERE INJURY OCCURRED OR DESCRIBE THE ONSET AND NATURE OF YOUR MEDICAL CONDITION INCLUDING SYMPTOMS. IF MORE SPACE IS NEEDED, PLEASE ATTACH SHEET OF PAPER.			
DATE FIRST TREATED / /	IF "HOSPITAL CONFINED", GIVE NAME AND ADDRESS OF HOSPITAL HOSPITAL: _____ Name Street Address City State Zip CONFINED FROM _____ THROUGH _____		
HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN? _____	TREATED BY: HOSPITAL: _____ Name Street Address City State Zip DOCTOR: _____ Name Street Address City State Zip		

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?							
YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No Fault	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other STD/LTD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU APPLIED, OR DO YOU PLAN TO APPLY FOR BENEFITS DESCRIBED ABOVE? YES NO
 TYPE _____ DATE APPLICATION FILED _____
 TYPE _____ DATE APPLICATION FILED _____

IF YOUR REQUEST FOR BENEFITS IS APPROVED, DO YOU WANT US TO WITHHOLD FEDERAL INCOME TAXES?
 YES NO INDICATE AMOUNT: \$ _____ (\$88 MINIMUM PER MONTH)

IF YOUR REQUEST FOR BENEFITS IS APPROVED, DO YOU WANT US TO WITHHOLD STATE INCOME TAXES?
 YES NO INDICATE AMOUNT: \$ _____ (PER MONTH)

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND COMPLETE. IF MY ANSWERS ON THIS CLAIM FORM ARE INCORRECT OR UNTRUE, OF IF I REFUSE TO SIGN THE AUTHORIZATION FOR RELEASE OF INFORMATION, REGENCE LIFE AND HEALTH INSURANCE COMPANY HAS THE RIGHT TO DENY MY CLAIM.

Signature of Employee _____ Date _____

FRAUD NOTICES

Unless specific state language is provided below, the following general 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.

AR & LA Residents: Any person who knowingly presents a false or fraudulent claim for payment of 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 Residents: For your protection, California law requires the following to appear on the 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 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 claim for 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 Div. of Ins. within the Department of Regulatory Agencies.

DC 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.

FL Residents: 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 is guilty of a felony of the third degree.

KS, MD, OR & VA Residents: 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 may be guilty of insurance fraud.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY 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 act, which is a crime, and 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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AUTHORIZATION FOR RELEASE OF INFORMATION (Excluding psychotherapy notes) (To be signed and dated by the insured/claimant)

I authorize 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 having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Regence Life and Health Insurance Company (RLH) and to its authorized claims administrators, Disability Reinsurance Management Services, Inc. (Disability RMS) and/or Integrated DisAbility Resources, Inc. (IDR), *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by RLH, Disability RMS, and/or IDR and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing RLH, Disability RMS and/or IDR solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying RLH, Disability RMS and/or IDR in writing, of my revocation. However, such revocation is not effective to the extent that RLH, Disability RMS and/or IDR have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the ability of RLH, Disability RMS and/or IDR to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

- If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

- If you reside in Minnesota or Wisconsin: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

- If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

- If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING RLH, DRMS and/or IDR to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and RLH, DRMS and/or IDR shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Signature (or Authorized Representative)* _____ Date: _____

Description of Personal Representative's Authority (If applicable):

*If signed by authorized representative, attach verification of identity

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NOTICE OF CLAIM FOR LONG TERM DISABILITY BENEFITS

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

NAME OF EMPLOYEE			OCCUPATION	CLASS	IS DISABILITY DUE TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DATE EMPLOYED / /	DATE INSURED / /	DATE LAST WORKED / /	REASON FOR STOPPING WORK <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 _____		<input type="checkbox"/> Disability <input type="checkbox"/> Dismissed		
DATE RETURNED TO WORK / / <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK	IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE: / /	DATE EMPLOYMENT TERMINATED / /	DATE DISABILITY INSURANCE TERMINATED / /			
REQUIRED NUMBER OF HRS. PER WEEK _____ hrs.	GROSS ANNUAL SALARY (not including overtime) during the 12 months just prior to your employee's disability \$ _____		PLEASE INDICATE HOW THE EMPLOYEE IS PAID (check all that apply): <input type="checkbox"/> hourly <input type="checkbox"/> salaried <input type="checkbox"/> other _____ <input type="checkbox"/> includes commissions? <input type="checkbox"/> includes bonuses?				
IS EMPLOYEE SUBJECT TO FICA TAX? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", IS EMPLOYEE SUBJECT TO <input type="checkbox"/> FULL FICA TAX ? <input type="checkbox"/> MEDICARE PORTION ONLY?							
PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (AS OF POLICY YEAR OF DISABILITY) EMPLOYEE <input type="checkbox"/> 100% <input type="checkbox"/> OTHER _____% IS EMPLOYEE CONTRIBUTION: <input type="checkbox"/> PRE-TAX DEDUCTION? EMPLOYER <input type="checkbox"/> 100% <input type="checkbox"/> OTHER _____% <input type="checkbox"/> AFTER-TAX DEDUCTION?							
EMPLOYEE ELIGIBLE FOR:							
YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No-fault	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other LTD/STD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTS TO THIS FORM:							
➤ The employee's Workers' Compensation claim(s) and Approval/Denial Notification							
➤ The employee's current job description							
I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.							
NAME OF POLICYHOLDER (COMPANY)			GROUP NO.	PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE			
MAILING ADDRESS OF POLICYHOLDER (COMPANY)			SIGNATURE	DATE			
(_____) - _____			(_____) - _____				
TELEPHONE NUMBER			FAX NUMBER				

PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE

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**ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN
(Please Print or Type)**

Name of Patient		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
_____ <small>FIRST MIDDLE LAST</small>			/ /	
Height _____	Weight _____	Blood Pressure (last visit) Systolic _____ / Diastolic _____		<input type="checkbox"/> Left-handed <input type="checkbox"/> Right-handed

1. HISTORY:

- a. Is condition due to Accident? Sickness?
- b. When did symptoms first appear or injury occur? Mo. _____ Day _____ Year _____
- c. Date patient was unable to work because of impairment Mo. _____ Day _____ Year _____
- d. Has patient ever had same or similar condition? Yes No If "Yes", state when and describe _____
- e. Is condition due to injury or sickness arising out of patient's employment? Yes No Please explain: _____
- f. Was this patient referred to you? Yes No If "Yes", by whom and what is their specialty? _____
- g. Have you referred this patient to another treating provider? Yes No If "Yes", to whom and what is their specialty? _____

2. DIAGNOSIS:

- a. Diagnosis impacting function: _____ ICD9 Code(s) _____
 Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____
- b. Secondary diagnosis impacting function: _____
 Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____
- c. Subjective symptoms: _____
- d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings): _____

3. DATES OF TREATMENT FOR THIS CONDITION:

- a. Date of first visit Mo. _____ Day _____ Year _____
- b. Date of last visit Mo. _____ Day _____ Year _____
- c. Next office visit Mo. _____ Day _____ Year _____
- d. Frequency Weekly Monthly Other (specify) _____

4. PROGRESS:

- (a) Has patient Recovered? Improved? Unchanged? Retrogressed?
- (b) Is patient Ambulatory? House confined? Bed confined? Hospital confined?
- If "Hospital Confined", give Name and Address of Hospital _____
- Confined from _____ through _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

