Disability Claim Filing Instructions

ALL PORTIONS OF THESE FORMS MUST BE COMPLETED IN ORDER TO EXPEDITE YOUR CLAIM.

CHECK LIST…

1. Have you completed the Employee's Statement in full?
2. Has the Attending Physician completed his/her statement in full?
3. Have you read, signed and dated the Authorization for Release of Information?
4. Have you sent the form to the on-site representative for completion of the Employer's Statement?
5. Have you attached a copy of your hospital statement if your disability claim included an overnight hospital stay?

Please submit the completed claim form to the address below

Pinellas County Schools
Risk Management & Insurance
301 4th Street SW
Largo, FL 33770

If you have any questions when completing this form, please contact 1-(727) 588-6444

Disability RMS
Fax -(866)-376-9480
Toll Free Phone 1-(866) 376-9478

NOTICE OF CLAIM FOR:

- ☐ **SHORT TERM DISABILITY BENEFITS**
- ☐ **LONG TERM DISABILITY BENEFITS**
- ☐ **HIP (Attach Hospital Statement)**
- ☐ **NON-DISABLING INJURY (Attach itemized bill including diagnosis)**

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 / /	☐ MALE ☐ FEMALE
☐ RIGHT-HANDED ☐ LEFT-HANDED	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED	IS SPOUSE EMPLOYED? ☐ YES ☐ 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: (During the 12 months just prior to your disability - for this employer only) $ _____	PLEASE INDICATE HOW YOU ARE PAID: ☐ 9 MOS./YR. ☐ 10 MOS./YR. ☐ 12 MOS./YR. ☐ OTHER _____	
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? ☐ YES ☐ NO	IF "YES", EXPLAIN: DID YOU FILE FOR WORKERS' COMPENSATION? ☐ YES ☐ 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? ☐ YES ☐ 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

FOR PREGNANCY DISABILITY ONLY:
Are there any present complications or anticipated difficulties in connection with the following?

a. Pregnancy ☐ YES ☐ NO Date of last menstrual period: _____ Expected date of delivery _____
b. Delivery ☐ YES ☐ NO Actual date of delivery: _____ ☐ Vaginal ☐ C-Section
c. Post Partum ☐ YES ☐ NO

If "Yes" to any of these, please specify in detail: _____
_____

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
☐	☐	Sick Pay	$ _____	_____	_____	☐	☐
☐	☐	Salary Continuance	$ _____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$ _____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ _____	_____	_____	☐	☐
☐	☐	No Fault	$ _____	_____	_____	☐	☐
☐	☐	Unemployment Compensation disability	$ _____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ _____	_____	_____	☐	☐
☐	☐	Retirement income (normal, early, or disability)	$ _____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$ _____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$ _____	_____	_____	☐	☐

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)

Florida 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.

Signature of Employee _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA Compliant)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, 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 (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and Union Security Insurance Company *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy 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 the information obtained by use of this authorization will be used by Disability RMS, Union Security Insurance Company 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, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Disability RMS or Union Security Insurance Company may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand 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 I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent Disability RMS and/or Union Security Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. I understand Union Security Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

*If you reside in **California:** this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

If you reside in **Connecticut, Maine, or Massachusetts: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

***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 Disability RMS 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 Disability RMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: _____ Date of Birth: _____

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

Description of Personal Representative's Authority (if applicable):
(If signed by authorized representative, attach verification of identity)

Disability RMS
Fax -(866)-376-9480
Toll Free Phone 1-(866) 376-9478

NOTICE OF CLAIM FOR ☐ SHORT TERM DISABILITY BENEFITS
☐ LONG TERM DISABILITY BENEFITS

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

NAME OF EMPLOYEE	OCCUPATION	IS DISABILITY DUE TO EMPLOYMENT? ☐ Yes ☐ No

DATE EMPLOYED	DATE INSURED	DATE LAST WORKED	REASON FOR STOPPING WORK
/ /	/ /	/ /	☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ 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:	DATE EMPLOYMENT TERMINATED	DATE DISABILITY INSURANCE TERMINATED
/ / ☐ Full-Time ☐ Part-Time	**Not Applicable**	/ /	/ /	/ /

REQUIRED NUMBER OF HOURS PER WEEK	GROSS ANNUAL SALARY (During the 12 months just prior to your employee's disability)	PLEASE INDICATE HOW THE EMPLOYEE IS PAID:
_____ hours	$ _____	☐ 9 Mos./Yr. ☐ 10 Mos./Yr. ☐ 12 Mos./Yr. ☐ Other _____

IS EMPLOYEE SUBJECT TO FICA TAX? ☐ Yes ☐ No
IF "YES", IS EMPLOYEE SUBJECT TO ☐ Full FICA Tax? ☐ Medicare Portion Only?

PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (as of policy year of disability)
EMPLOYEE ☐ 100% ☐ Other _____%
EMPLOYER ☐ 100% ☐ Other _____%
IS EMPLOYEE CONTRIBUTION: ☐ Pre-Tax Deduction? ☐ After-Tax Deduction?

EMPLOYEE ELIGIBLE FOR:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay	$ _____	_____	_____	☐	☐
☐	☐	Salary Continuance	$ _____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$ _____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ _____	_____	_____	☐	☐
☐	☐	No Fault	$ _____	_____	_____	☐	☐
☐	☐	Unemployment Compensation disability	$ _____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ _____	_____	_____	☐	☐
☐	☐	Retirement income (normal, early, or disability)	$ _____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$ _____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$ _____	_____	_____	☐	☐

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 prior year's W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability
- The employee's current job description

Florida 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.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

PINELLAS COUNTY SCHOOL , SPVR. BENEFITS & WORKERS' COMPENSATION

NAME OF POLICYHOLDER (COMPANY) *PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE*

301 4TH STREET SW
LARGO, FL 33770

MAILING ADDRESS OF POLICYHOLDER (COMPANY) *SIGNATURE* *DATE*

(727) 588 - 6444 *TELEPHONE NUMBER*
(727) 588 - 6182 *FAX NUMBER*

PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE

Disability RMS
Fax 1-(866)-376-9480
Toll Free Phone 1-(866) 376-9478

ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN

(Please Print or Type)

Name of Patient _____ *FIRST* *MIDDLE* *LAST*	☐ Male ☐ Female	Date of Birth / /
Height _____ Weight _____	Blood Pressure (last visit) Systolic _____/ Diastolic _____	☐ Left-handed ☐ 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: _____ ICD Code(s) _____
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

_____

_____

b. Secondary diagnosis impacting function: _____ ICD Code(s) _____
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. FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with the following?

d. Pregnancy ☐ Yes ☐ No Date of last menstrual period: _____ Expected date of delivery _____

e. Delivery ☐ Yes ☐ No Actual date of delivery: _____ ☐ Vaginal ☐ C-Section

f. Post Partum ☐ Yes ☐ No

If "Yes" to any of these, please specify in detail: _____

_____

4. 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) _____

5. 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

6. CARDIAC (if applicable)

Functional Capacity (American Heart Assoc. standards) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

7. CURRENT FUNCTIONAL ABILITY

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

___ Hrs. Sedentary Activity 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.

___ Hrs. Light Activity 20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.

___ Hrs. Medium Activity 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.

___ Hrs. Heavy Activity 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

b. Please check appropriate box:

	Occasionally (0% to 33%)	Frequently (33% to 66%)	Continuously (66% to 100%)
Bending	☐		☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push/pull	☐ No. of lbs. _____	☐ No. of lbs. _____	☐ No. of lbs. _____
Lifting (lbs.)	☐ No. of lbs. _____	☐ No. of lbs. _____	☐ No. of lbs. _____

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific.

_____

_____

d. Upper Extremity Function - Please indicate upper extremity functional capabilities:

Simple grasp	☐ Left	☐ Right	Comments _____
Pinch	☐ Left	☐ Right	Comments _____
Fine manipulation	☐ Left	☐ Right	Comments _____
Power grip	☐ Left	☐ Right	Comments _____
Repetitive motion	☐ Left	☐ Right	Comments _____

8. MENTAL HEALTH ABILITY (if applicable)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

_____

_____

9. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b. The date you released patient to return to work: Mo._____ Day _____ Year _____

☐ Full-time ☐ Reduced hours Number of hours: _____

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

_____

_____

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ATTENDING PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME (PLEASE PRINT)_____

DEGREE/SPECIALTY _____

TELEPHONE NUMBER (_____)_____-_____ FAX NUMBER (_____)_____- _____ TAX ID # _____

OFFICE ADDRESS _____

NUMBER/STREET

_____

CITY OR TOWN *STATE* *ZIP CODE*

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE