USAble Life
Live life. You're covered.℠

PO Box 1650
Little Rock, AR 72203-1650

Short Term Disability
Instructions for Filing Claims

Dear Insured:

USAble Life is pleased to provide you coverage when you are unable to work due to a covered disability. We have included these instructions and the necessary forms to assist you in the event you need to file a claim for short term disability benefits. Please remember that all forms must be received within 90 days of the date you stop work.

Employee Statement

1. Complete the Employee Statement in full.
2. Answer all questions or state "not applicable".
3. Review the attached Fraud Statement as it applies to your state of residence, sign and date.
4. Sign and date the Authorization form.

Employer & Attending Physician Statements

1. Obtain the statement of your Attending Physician who will certify your disability.
2. Obtain the statement of your Employer.

Return All Forms to USAble Life:

Email: claims@usablelife.com

Facsimile: (501) 235-8417

Mail: PO Box 1650, Little Rock, AR 72203-1650

For Questions or Assistance Call or Contact USAble Life:

Telephone: (800) 370-5856 **Email:** claims@usablelife.com

USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856 Fax (501) 235-8417
E-mail: claims@usablelife.com

Statement of Claim
Short Term Disability
Income Benefits
Employee's Statement

For H.O. Use Only	
Eff	
PTD	
Benefits	

Instructions

1. **Please type or print in blue or black ink.**
2. **Please make sure all questions on Employee's Statement are completed in full.**
3. **Employer's and Physician's Statements must be completed.**
4. **Authorization and Fraud Notice must be signed and currently dated.**
5. **Email, fax or mail the completed form to USAble Life.**

EMPLOYEE'S STATEMENT

Full Name (First, Middle, Last)	Social Security Number	Gender ☐ Male ☐ Female
Street Address	Date of Birth	Occupation
City, State, Zip	Telephone Numbers Home / Work	
Claim is for ☐ Accident ☐ Sickness ☐ Pregnancy	Nature of Accident or Sickness	

Date of 1st Treatment	Physician or Hospital First Treated By	First Full Day of Disability

If accident, how did the accident occur? _____

Accident Date _____ Time _____ ☐ A. M. ☐ P.M. Place _____

Was a third party responsible for accident? ☐ Yes ☐ No If Yes, third party's name _____

Third party's address _____

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement)	☐ Yes ☐ No $_____ Mo.	V.A. Benefits:	☐ Yes ☐ No $_____ Mo.
Dependent Social Security:	☐ Yes ☐ No $_____ Mo.	Worker's Compensation:	☐ Yes ☐ No $_____ Wk.
Sick Leave or Wage Continuation:	☐ Yes ☐ No $_____ Wk.	Other Disability Coverage:	☐ Yes ☐ No $_____ Wk.
Retirement: (normal, early or disability)	☐ Yes ☐ No $_____ Mo.	(identify)	_____
State Disability Income:	☐ Yes ☐ No $_____ Wk.	**Include a copy of your award or denial letter for any source in which one has been received.**	
Unemployment:	☐ Yes ☐ No $_____ Wk.		

Names and addresses of all doctors consulted for **this** condition (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code

Have you ever had this or similar condition before? ☐ Yes ☐ No If yes, give particulars: Date _____

Describe _____

Names and addresses of all doctors seen for **any** condition in the past five years (Use separate sheet if necessary):

Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition

USAble Life

P.O. Box 1650 – Little Rock, Arkansas 72203-1650

FRAUD NOTICE

AZ Residents Only: Upon written request, we will provide you with information regarding the benefits and provisions of the annuity contract for which you are applying. If you are not satisfied with this contract, you may return it within 10 days, or 30 days if the owner is age 65 or over, after the date you receive it. Any premium paid will be refunded without interest.

AR, LA, NM, and OK Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime in certain states, a felony. Penalties may include imprisonment.

CA Residents Only: § 789.8 The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties. You or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

District of Columbia Residents Only: 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 Only: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY and PA Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MD Residents Only: "Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

ME and TN Residents Only: 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.

OH Residents Only: Any person who, with the 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.

Rhode Island Residents Only: 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."

VA Residents Only: 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.

WA Residents Only: 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.

_____ _____

Date Signature

USAble Life

P.O. Box 1650
Little Rock, AR 72203-1650

Authorization to Disclose, Obtain and Use Personal Information

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the Medical Information Bureau, benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

I have executed this authorization intending that it will be effective on and after

_____
(Date)

_____ _____
Signature Printed Name

Return original with your claim & retain a copy of this authorization and claim form for your records.

USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856 Fax (501) 235-8417
E-mail: claims@usablelife.com

Statement of Claim
Short Term Disability Income Benefits
Attending Physician's Statement

Instructions

1. **Physician certifying disability must complete all questions, sign and date this Attending Physician's Statement.**
2. **Email, fax or mail the completed form to USAble Life.**

ATTENDING PHYSICIAN'S STATEMENT

Neither the Employee nor the Employer should complete or alter any part of this statement.

Patient's Full Name (First, Middle, Last)	Date of Birth

Diagnosis & Concurrent Conditions	ICD Codes
1.	1.
2.	2.

Disability is due to

☐ Accident ☐ Sickness ☐ Pregnancy

If accident, provide how, when and where accident occurred _____

_____

_____

If Pregnancy, _____ ☐ Actual ☐ Estimated
Delivery Date

Date of LMP _____

Type of Delivery ☐ Vaginal ☐ C-section

_____

Date Symptoms First Appeared _____

Date Patient First Consulted You _____

Dates & Surgical Procedures (if any) _____

_____

_____

If hospitalized, ☐ Inpatient ☐ Outpatient

Date Admitted_____ Date Discharged _____

Full Name of Hospital _____

Address _____

City, State, Zip Code _____

_____

Telephone # of Hospital _____

Is Disability due to injury or sickness arising out of or in the course of patient's employment? ☐ Yes ☐ No

_____

How long was or will patient be unable to work due to disability?

From _____ Through _____

Can return to work on _____

Please list all treatment dates during the month in which the disability began _____

_____

Date of next doctor's appointment _____

List Restrictions and Limitations_____

_____

_____

_____

Has patient ever had same or similar condition?

☐ No ☐ Yes Date _____

Describe any circumstances causing disability to be prolonged:

Physician's Signature	Date
Physician's Name (Please Print/Type)	Degree
Address	Telephone
City State Zip Code	Fax

FRAUD WARNING: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act.

USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856 Fax (501) 235-8417
E-mail: claims@usablelife.com

Statement of Claim
Short Term Disability Income Benefits
Employer's Statement

Instructions

1. **Employer must complete all questions, sign and date this Employer's Statement.**
2. **Email, fax or mail the completed form to USAble Life.**

EMPLOYER'S STATEMENT

Employee Name (First, Middle, Last)		Date of Birth	Social Security Number
Group Policy Number	Date of Hire	Coverage Effective Date	Weekly STD Benefit $

Last Day Worked	Date Returned to Work	Base Salary $ _____
Date _____	☐ Full-Time _____	☐ Hourly ☐ Monthly
# of Hours _____	☐ Part-Time_____	☐ Weekly ☐ Annually

Employee Regularly Works _____ Hours Per Week | Employee's Occupation

Check Days Normally Worked?	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat

If on rotation, give number of days worked per week: _____

Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? ☐ Yes ☐ No

If yes, Status of claim? ☐ Pending ☐ Approved ☐ Denied ☐ Denial on Appeal

Name of Worker's Compensation Carrier: _____

Address of Worker's Compensation Carrier: _____

_____

Employee received: Salary continuation through _____ Vacation pay through _____ Sick pay through _____

Employer Name	Email address	Tax ID #
Signature	Title	Date
Name (Please print or Type)	Telephone	Fax

Street Address City State Zip Code

FRAUD WARNING: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act.