FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 45132
JACKSONVILLE, FLORIDA 32232-5132
ATTN: Group Claims Department

GROUP SHORT TERM DISABILITY & HOSPITAL INDEMNITY CLAIM STATEMENT

POLICYHOLDER CERTIFICATION

EMPLOYER INSTRUCTIONS - Notice of Claim

A. **Complete Section 1, Part I, of this form in full.**

B. **Complete Section 1, Part II, of this form ONLY if claimant is an employee.**

Include:

- Job description (detailed duties);
- Copy of enrollment card (if employee contributes to premium);
- Copy of approved medical evidence of insurability if required at time of enrollment;
- Documentation of earnings if other than straight salary;
- If Workers' Compensation claim filed include copy of First Report of Accident and the decision.

C. **Give Section 2 to Employee's Supervisor to be completed in full, if claimant is an employee.**

D. **Mail Section 1 and Section 2 to: Attention: Group Claims Department at the above shown address.**

E. **Give remaining Section 3 and Section 4 to claimant for completion.**

F. **If claimant has more than one treating physician, give claimant additional forms for completion.**

G. **All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.**

It is the responsibility of you and the claimant to inform us of any scheduled or actual return to work date as soon as possible.

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

5011 GATE PARKWAY, BLDG. 200 • JACKSONVILLE, FLORIDA 32256
ATTN: Group Claims Department

GROUP SHORT TERM DISABILITY & HOSPTIAL INDEMNITY CLAIM STATEMENT

To receive claims assistance, please call 1-800-696-8562 **Employer's Statement**

SECTION 1: TO BE COMPLETED BY EMPLOYER (Please Print)

Part I: Complete boxes 1 – 9 with information on the **employee.** Also complete boxes 30 – 32.

1. Full legal name of employee:	2. Date of birth (Mo/Day/Yr):	3. Social Security number:
4. Address: City: State: Zip Code:		
5. Employee's Home Telephone Number: ( )	6. Date of hire (Mo/Day/Yr):	7. Employee's Insurance Effective Date (Mo/Day/Yr):
8. Group policy number:	9. Type of coverage claim is being made for: ☐ STD ☐ HIP	

Part II: Complete boxes 10 – 29 **if claimant is an employee.** Also complete boxes 30 – 32.

10. Employee's Insurance Class:	11. Job title at time last actively worked:	
12. Date of last salary increase (Mo/Day/Yr):	13. Date last worked (Mo/Day/Yr):	14. Hours worked that day:
15. Work schedule at time last actively worked: Number of days per week:_____ Number of hours per day: _____	16. If not at work when disability began, check employee's status and provide date: ☐ Terminated ☐ Leave of Absence ☐ Laid Off ☐ Sick Leave ☐ Vacation ☐ Resigned ☐ Other (specify) _____ Date _____	
17. How was employee paid and what was the amount? (check appropriate box): ☐ Hourly ☐ Monthly ☐ Salary and Commissions ☐ Weekly ☐ Commissions ☐ Salaried and Bonus ☐ Bi-weekly ☐ Salaried ☐ Commissions Only Amount $_____	18. Date paid thru (Mo/Day/Yr):_____ Paid thru for: ☐ Regular Salary ☐ Salary Continuation ☐ Vacation ☐ Accrued Sick Leave ☐ Other	
19. Has Employee returned to work? ☐ Yes ☐ No If yes, (Mo/Day/Yr):_____ ☐ Full time ☐ Part time	20. Were there any changes to the employee's job responsibilities due to medical condition before the employee stopped working? ☐ Yes ☐ No If yes, what were the changes and when were they made?	
21. Does the employee contribute toward the premium? ☐ Yes ☐ No If yes, ☐ Pre-Tax ☐ Post-Tax If Post-Tax _____% paid by Employer _____ % paid by Employee		
22. Do you have a pension plan? ☐ Yes ☐ No (If yes, what type?)	23. Is the employee eligible for the pension plan? ☐ Yes ☐ No (If no, why?)	
24. If eligible, does the employee participate in pension plan? ☐ Yes ☐ No	25. What % does the employee contribute to the pension plan? _____%	26. If the employee participates in the pension plan, when is he/she eligible for benefits: ☐ Early Retirement ☐ Normal Retirement ☐ Disability Retirement Provide date:_____

27. Employee is eligible for:	Yes	No	If yes, amount:	Weekly	Monthly	Date Benefits Begin (Mo/Day/Yr):	Date Benefits will end (Mo/Day/Yr):
Salary Continuation	☐	☐	$	☐	☐		
Social Security	☐	☐	$	☐	☐		
Short Term Disability	☐	☐	$	☐	☐		
Unemployment	☐	☐	$	☐	☐		
State Disability	☐	☐	$	☐	☐		
Workers' Compensation	☐	☐	$	☐	☐		
Has Workers' Comp. claim been filed?	☐	☐	If Workers' Compensation has been filed, submit copy of first report with this claim. If Workers' Compensation has been denied, submit copy of denial with this claim.				

28. Name/Address of employee's medical insurance carrier or HMO (Provide policy or ID number):

Name/Address of Workers' Compensation Carrier:

29. Does your company have a rehire or return to work policy for disabled employees? ☐ Yes ☐ No

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30. Employer's name (State name of policyholder, if different): Telephone number: ( ) Fax number: ( )

31. Address of Employer: City: State: Zip Code:

32. Employer's authorized group benefits administrator:
Name (Please print): _____ Title: _____
Signature: (The above statements are true and complete to the best of my knowledge): _____ Date:_____

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5011 GATE PARKWAY, BLDG. 200 • JACKSONVILLE, FLORIDA 32256
ATTN: Group Claims Department

GROUP SHORT TERM DISABILITY & HOSPITAL INDEMNITY CLAIM STATEMENT

INSTRUCTIONS FOR THE EMPLOYEE'S SUPERVISOR:

1. Print or type complete answers to the "Employee's Supervisor" section. Attach extra paper, if needed. Sign and date it.
2. Give completed form to Employer to be **mailed** with "Employer" section to: **Attention: Group Claims Department** at the above shown address.

To receive claims assistance, please call 1-800-696-8562 **Job Analysis**

SECTION 2: TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR (Please Print)

1. Full legal name of employee:	2. Social Security number:	3. Job Title:

4. Does the employee perform supervisory functions: ☐ Yes ☐ No If yes, how many people are supervised?_____
Describe job duties:

5. Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time;
Frequently means the person does the activity 34% to 66% of the time;
Continuously means the person does the activity 67% to 100% of the time.

	Occasionally	Frequently	Continuously
Relate to Others	☐	☐	☐
Written and verbal communication	☐	☐	☐
Reasoning, math and language	☐	☐	☐
Makes independent judgments	☐	☐	☐

6. Which of the following describes the employee's working environment (check all that apply):

☐ Unprotected heights	☐ Changes in temperature or humidity	☐ Exposure to dust, fumes and gases
☐ Being near moving machinery	☐ Driving automotive equipment	☐ Other hazards

7. Is the employee required to travel? ☐ Yes ☐ No If yes, complete the following information:

How does the employee travel? (Automobile, plane, train, etc.)	Where does the employee travel?	What percent of the time does the employee travel?

8. Check the items below that relate to the employee's job and complete the information requested.
Occasionally = 0% - 33% Frequently = 34% - 66% Continuously = 67% - 100%

	Occasionally	Frequently	Continuously	Describe Activity	Weight
☐ Standing	☐	☐	☐		
☐ Walking	☐	☐	☐		
☐ Sitting	☐	☐	☐		
☐ Balancing	☐	☐	☐		
☐ Stooping	☐	☐	☐		
☐ Kneeling	☐	☐	☐		
☐ Crouching	☐	☐	☐		
☐ Crawling	☐	☐	☐		
☐ Reaching/working overhead	☐	☐	☐		
☐ Climbing	☐	☐	☐		
☐ Stairs Number of stairs:_____	☐	☐	☐		
☐ Ladders Height of ladder: _____	☐	☐	☐		
☐ Pushing	☐	☐	☐	_____	_____ lbs.
☐ Pulling	☐	☐	☐	_____	_____ lbs.
☐ Lifting/carrying	☐	☐	☐	_____	_____ lbs.

(Continued on reverse side.)

9. Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

10. Does the job require using the feet to operate foot controls? ☐ Yes ☐ No If yes, on what type of equipment?

11. How important is good vision in the job?

12. What are the major tasks requiring use of one or both hands?

	One Hand	Both Hands
_____	☐	☐
_____	☐	☐
_____	☐	☐
	☐	☐

13. Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No
If yes, explain.

14. Is it possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)? ☐ Yes ☐ No If yes, explain.

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15. Name of person completing this form: Title: Date:

16. Signature (The preceding statements are true and complete to the best of my knowledge):

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5011 GATE PARKWAY, BLDG. 200 • JACKSONVILLE, FLORIDA 32256
ATTN: Group Claims Department

GROUP SHORT TERM DISABILITY & HOSPITAL INDEMNITY CLAIM STATEMENT

INSTRUCTIONS FOR THE INSURED OR HIS AUTHORIZED REPRESENTATIVE:

1. Print or type complete answers to the "Claimant's Report of Claim" and sign the "Authorization to Release Information" on the reverse side. If guardianship or power of attorney has been executed, please attach certified copies of the official designation. Attach extra paper, if needed. Sign and date it.
2. Attach:
   - Birth Certificate (short duration claim and under age 50 not necessary at this time);
   - Copy of awards from other source of benefits: Social Security, Workers' Compensation, Retirement, State Disability, Other.
3. Give the attached "Attending Physician's Statement" to your physician and have him complete it. If you have more than one treating physician, provide each one with an Attending Physician's Statement.
4. Have your attending physician **mail** the form to: **Attention: Group Claims Department** at the above shown address.
5. All portions of this form package must be completed to avoid undue delay in processing your request for benefits.
6. It is the responsibility of you and the employer to inform us of any scheduled or actual return to work date as soon as possible.

To receive claims assistance, please call 1-800-696-8562 **Claimant's Statement**

SECTION 3: CLAIMANT'S REPORT OF CLAIM (Please Print)

1. Full legal name of insured:			2. Date of birth (Mo/Day/Yr):	3. Social Security number:
4. Address: City: State: Zip code:				5. Telephone number: ( )
6. Height:	7. Weight:	8. Sex: ☐ M ☐ F	9. Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
10. If married, spouse's name: Date of birth (Mo/Day/Yr): Social Security number:				11. Is spouse employed? ☐ Yes ☐ No
12. Number of children (under age 19)		13. Names and birth dates of children who have not finished high school:		
14. Name of employer (State name of policyholder, if different.):			15. Group policy number:	16. Division Number:
17. List occupation duties at the time of disability:			18. If injury or sickness is related to your occupation, please explain:	
19. Date of injury or date of first symptoms (Mo/Day/Yr):	20. Last day you worked because of disability (Mo/Day/Yr):		21. Date you returned to work (Mo/Day/Yr): ☐ Part-time _____ ☐ Full-time _____	22. Have you or do you intend to file a workers' compensation claim? ☐ Yes ☐ No
23. Disability is due to: ☐ injury ☐ sickness	24. Describe when, where, and how injury occurred, or describe the onset and nature of the sickness.			

25. Date you were first treated for your injury or sickness (Mo/Day/Yr): _____
Treated by: Name: Address (street, city, state, zip code):
Hospital: _____
Doctor: _____

26. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
Treated by: Name: Address (street, city, state, zip code):
Hospital: _____
Doctor: _____

27. Describe income you are now receiving or plan to apply for:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE ENDED
☐	☐	Social Security (☐ Retirement ☐ Disability)	$_____	_____	_____
☐	☐	State disability	$_____	_____	_____
☐	☐	Retirement (☐ Normal ☐ Early ☐ Disability)	$_____	_____	_____
☐	☐	Workers' compensation	$_____	_____	_____
☐	☐	Group disability benefits	$_____	_____	_____
☐	☐	Other (Describe.): _____	$_____	_____	_____

28. Do you want Federal Withholding Tax deducted? ☐ Yes ☐ No
(If yes, $10.00 or 10%, whichever is greater, will be deducted for STD benefits, and you must also attach Form W-4P.)

(Continued on reverse side.)

AUTHORIZATION TO RELEASE INFORMATION

I authorize persons or entities that have any records or knowledge of me or my health to release such information to Florida Combined Life Insurance Company, Inc. (FCL), or its reinsurers. These persons or entities include any: 1. licensed physician; 2. medical practitioner; 3. hospital; 4. clinic or other medical or medically-related provider; 5. employer; 6. consumer reporting agency; 7. insurance company; or 8. other organization, institution, or person. This information may also be released to any affiliated or reinsurance carrier. These releases specifically include, but are not limited to, authorization to release: 1. any and all medical records; and 2. information about, associated with, or with reference to certain conditions. These conditions include, but are not limited to: 1. a positive test result for Human Immunodeficiency Virus (HIV) infection; 2. AIDS-Related Complex (ARC); 3. Acquired Immune Deficiency Syndrome (AIDS); 4. drug addiction; 5. alcoholism; or 6. mental illness. This information will be used to evaluate this request for claims proceeds. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by FCL to collect and transmit such information.

I also authorize FCL, at its sole discretion, to release claims information to other insurers. This claims information includes specific medical information on me. These releases specifically include, but are not limited to, authorization to release: 1. any and all medical records; and 2. information about, associated with, or with reference to certain conditions. These conditions include, but are not limited to: 1. a positive test result for HIV infection; 2. ARC; 3. AIDS; 4. alcohol or drug dependency; and 5. mental and nervous disorders.

I authorize FCL to exchange benefit information with any: 1. insurance company; 2. organization; or 3. individual. This exchange is to determine if a coordination of benefit applies. When an overpayment is made, I authorize FCL to recover the excess from any person to which payment is made.

A photocopy of this authorization shall be as valid as the original.

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I hereby certify that the statements on this form, including any attachment to it, are true and complete. I understand and agree that any misstatements may result in benefit denial.

Patient's (Claimant's) signature	Date
Authorized person's signature	Relationship of authorized person, if other than Claimant

Note: ***A true copy of this authorization is available to the claimant or his authorized representative at any time, upon request.***

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5011 GATE PARKWAY, BLDG. 200 • JACKSONVILLE, FLORIDA 32256
ATTN: Group Claims Department

GROUP SHORT TERM DISABILITY & HOSPITAL INDEMNITY CLAIM STATEMENT

INSTRUCTIONS FOR THE ATTENDING PHYSICIAN:

1. Print or type complete answers to the "Attending Physician's Statement" section. Attach extra paper, if needed. Sign and date it.
2. **Mail** this form, with "Claimant's Report of Claim" Section 3 to: **Attention: Group Claims Department** at the above shown address.

To receive claims assistance, please call 1-800-696-8562 **Physician's Statement**

SECTION 4: ATTENDING PHYSICIAN'S STATEMENT (Please Print)		
1. Patient's full legal name:	2. Date of birth (Mo/Day/Yr):	3. Social Security number:
4. Date injury happened or symptoms first appeared (Mo/Day/Yr):	5. Date patient ceased active work because of disability (Mo/Day/Yr):	6. Can condition be traced to patient's employment? ☐ Yes ☐ No ☐ Unknown
7. Patient status: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed ☐ Ambulatory ☐ Bed-confined ☐ House-confined ☐ Hospital-confined	8. Frequency of visits: Date of first visit (Mo/Day/Yr): _____ Date of last visit (Mo/Day/Yr): _____ ☐ Weekly ☐ Monthly ☐ Other *(Specify.)*: _____	
9. Subjective symptoms:		
10. Objective findings (including current x-rays, EKGs, laboratory data, and any clinical findings):		
11. If patient has ever had same or similar condition, please state when and describe:		
12. Diagnosis (including complications):		
13. Is condition related to pregnancy? ☐ Yes ☐ No If yes, estimated date of delivery (Mo/Day/Yr): _____		
14. Nature of treatment (including surgery and prescribed medications, if any):		
15. Other treating physicians:	Addresses:	Dates:
16. Hospital confinements:	Addresses:	Dates:

(Continued on reverse side.)

17. Blood pressure (last visit):

19. Functional capacity:
- ☐ Class 1 – No limitation
- ☐ Class 2 – Slight limitation
- ☐ Class 3 – Marked limitation
- ☐ Class 4 – Complete limitation

18. Physical impairments:
- ☐ Class 1 – No limitation of functional capacity; capable of heavy work. No restrictions. (0-10%)
- ☐ Class 2 – Medium manual activity. (15-30%)
- ☐ Class 3 – Slight limitation of functional capacity; capable of light work. (35-55%)
- ☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/ administrative (sedentary) activity. (60-70%)
- ☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

20. Mental impairments:

(a) Please define "stress" as it applies to this insured.

_____

(b) What stress and problems in interpersonal relations has insured had on the job?

_____

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
- ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
- ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations).

21. Is patient totally disabled? (Explain in item #29.)
- ☐ Patient's job ☐ Yes ☐ No
- ☐ Any other work ☐ Yes ☐ No

22. Date patient became disabled due to present illness (Mo/Day/Yr):

23. Is patient still under your care for this condition?
- ☐ Yes ☐ No

24. Do you expect a marked change in the future?
- ☐ 1 Month ☐ 3-6 Months ☐ Never
- ☐ 1-3 Months ☐ Other *(Specify)*: _____

Applies to:
- ☐ Patient's job
- ☐ Any other work

25. Is patient a suitable candidate for occupational rehabilitation? (Explain in item #29)
- ☐ Patient's job ☐ Yes ☐ No
- ☐ Any other work ☐ Yes ☐ No

26. Can present job be modified to allow for handling with impairment?
- ☐ Yes ☐ No

27. How long was or will patient be disabled (unable to work)?

From (Mo/Day/Yr): _____
Through (Mo/Day/Yr): _____

28. If employer can accommodate patient's limitations and restrictions is patient able to return to work? ☐ Yes ☐ No
What date could employment begin? _____

29. Remarks (use for additional comments or expansion of answers above):

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30. Name of attending physician (Please print):

31. Degree:

32. Specialty:

33. Telephone Number: ( )

34. Fax Number: ( )

35. Address: City: State: Zip code:

36. Signature (the attending physician's signature is required): Date: