



Long Term Disability Claim Filing Instructions

Have you...

- 1) Completed the **Employee's Statement**?
 - a) Incomplete, unsigned, or undated statements will delay your claim
- 2) Signed and dated the **Authorization for Release of Information**?
- 3) Had the physician treating you sign and date the **Attending Physician's Statement**?
 - a) The Attending Physician's Statement must be returned to you upon completion
- 4) Had your Employer sign and date the **Employer's Statement**?

All portions of these forms must be completed in order to expedite your claim. Our review of your claim will not begin until we receive all sections.

**Submit the completed statements to the address below or
fax to 1(207) 766-3448**

**LifeMap Claims
300 Southborough Drive
Suite 200
South Portland, Maine 04106-6914**

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

**Toll-Free Phone Number 1(877) 254-0085
Email: claims@disabilityrms.com**

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Employee Name: _____
Employer Name: _____
Group Number: _____



FRAUD NOTICE

Unless specific state language is provided below, the following 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.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado 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 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 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.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New York 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 insurance act, which is a crime 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.

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

Ohio 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 is guilty of insurance fraud.

Maine, Tennessee, Virginia and Washington Residents: 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.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma 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.

Employee Name: _____
Employer Name: _____
Group Number: _____



**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, a Family Medical Leave Act (FMLA) vendor, 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 LifeMap Assurance 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 LifeMap Assurance 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, (c) an FMLA vendor that may assist me in filing an FMLA claim, and (d) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand LifeMap Assurance 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 LifeMap Assurance Company in writing, of my revocation. However, such revocation is not effective to the extent LifeMap Assurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. I understand and LifeMap Assurance 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 LifeMap Assurance 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 LifeMap Assurance Company 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 LifeMap Assurance Company 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)

Employee Name: _____
 Employer Name: _____
 Group Number: _____



NOTICE OF CLAIM FOR LONG TERM DISABILITY BENEFITS

Fax 1 (207) 766-3448
 Toll Free Phone 1 (877) 254-0085

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

NAME OF EMPLOYEE			OCCUPATION		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: (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"/> Hourly Rate: _____ <input type="checkbox"/> Salaried <input type="checkbox"/> Other _____ <input type="checkbox"/> Includes Commissions or Bonuses <input type="checkbox"/> Includes Overtime Pay				
CLASS CODE							
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?							
What percentage of the LTD premium does the Employer pay? _____% Are employer paid premiums included in Employee's salary? <input type="checkbox"/> YES <input type="checkbox"/> NO Is Employee contribution: <input type="checkbox"/> Pre-Tax Deduction <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:							
<ul style="list-style-type: none"> ➤ 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 							
I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.							
NAME OF POLICYHOLDER (COMPANY)			PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE				
MAILING ADDRESS OF POLICYHOLDER (COMPANY)			SIGNATURE		DATE		
LOCATION CODE: _____			EMAIL ADDRESS: _____				
(_____) _____ - _____ Ext _____			(_____) _____ - _____				
TELEPHONE NUMBER			FAX NUMBER				

PLEASE COMPLETE AND RETURN THIS FORM

Employee Name: _____
 Employer Name: _____
 Group Number: _____



Fax 1 (207) 766-3448
 Toll Free Phone 1 (877) 254-0085

ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN WITHOUT EXPENSE TO INSURANCE COMPANY.

(Please Print or Type)

Name of Patient _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____
FIRST _____	MIDDLE _____		
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: _____ Diagnosis Code(s) _____
 Nature of treatment (including surgery with procedure code(s) and medications prescribed, if any, including dosage and frequency) _____
- b. Secondary diagnosis impacting function: _____ Diagnosis Code(s) _____
 Nature of treatment (including surgery with procedure code(s) 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:
- (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: _____

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

