200 SW Market Street, Suite 800
Portland, OR 97201

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free: 1 (800) 286-1129
Fax: (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Statement of Short Term Disability

Claim Filing Instructions

This Statement of Short Term Disability (STD) includes the forms required to apply for STD benefits.
If a form is received incomplete, unsigned or undated, it will be returned to you for completion, delaying the claim.

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**?
   a) The Employer's Statement must be returned to you upon completion

You are responsible for ensuring all forms are completed and returned to our office. Our review of your claim will not begin until we receive all completed forms.

Forms can be sent to LifeMap via:

Email: **claims@lifemapco.com**

Fax: **1 (855) 733-4615**

Regular Mail: **LifeMap Assurance Company**
Attn: Life and Disability Claims Department
200 SW Market Street, Suite 800
Portland, OR 97201

You must notify LifeMap promptly if:
- Your medical condition improves so you would be able to work, even if you have not yet returned to work.
- You go to work in any capacity for any employer, even as a self-employed person.
- You receive any other income related to your disability.

If you have any questions, please call the LifeMap Life and Disability Claims Department at 1 (800) 286-1129.

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Employee's Statement

Employee

Employee Name (Last, First, Middle Initial)				Social Security Number
Mailing Address Street & Number		City	State	Zip
Home Phone Number	Cell Phone Number	Email Address	Date of Birth	☐ Male ☐ Female

Employment

Employer Name	Employer Phone Number	Group Policy Number
Date you returned (or expect to return) to work on a **part-time** basis:	Date you returned (or expect to return) to work on a **full-time** basis:	
Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____		

Medical Information

Date First Treated:	First date unable to work because of disability:
Date of injury or date first noticed symptoms of illness:	Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If Yes, when

Is your injury or illness related to your occupation? ☐ Yes ☐ No ☐ Unsure	Did you file for Workers' Compensation? ☐ Yes ☐ No ☐ Not Yet	Workers' Compensation claim status: ☐ Pending ☐ Approved ☐ Denied (**include copy of denial letter**)

Cause of Disability: ☐ Accident ☐ Illness ☐ Pregnancy	Please explain illness or accident (include date and location):

Attending Physician

Primary Physician:	Phone Number	Hospital	
Street Address City State Zip	Fax Number	Date Admitted	Date Discharged

Other Sources of Income

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

Type	$ Amount (per week)	Date Began	Date Ended	Type	$ Amount (per week)	Date Began	Date Ended
Social Security (SSA)				Pension			
SSA Dependent's				State Disability / State Leave			
Workers' Compensation				Other (describe):			

Acknowledgement

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.

▶ _____ ▶ _____
Employee's Signature Date

Please complete Authorization to Obtain and Release Information form on page 4.

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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.

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Authorization to Obtain and Release Information

I authorize persons or entities having any records or knowledge of me or my health, including 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:

To give Medical information including chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results and prognosis with respect to any physical or mental condition and/or treatment of me, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records which may have been acquired in the course of examination or treatment.

If the information to be disclosed contains any of the types or information listed below, additional laws relating to the use and disclosure may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information:

_____ Drugs/Alcohol diagnosis, treatment or referral information
_____ Mental Health information – including provider notes
_____ HIV/AIDS information
_____ Genetic Testing Information

And Non-medical information including education, employment history, earnings or finances, vocational evaluation reports, vocational testing and rehabilitation plans, or eligibility for other benefits including retirement benefits and retirement plan contributions (for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claim status, benefit amounts, effective dates, etc.).

To LifeMap Assurance Company (LifeMap) and to its authorized representatives.

- I understand that the information obtained by use of this authorization will be used by LifeMap and authorized representatives to evaluate and adjudicate my current disability claim and, in order to assist with the evaluation and adjudication of my current disability claim, may be re-disclosed to (a) my employer (for return to work and accommodation discussions, including dates of birth related to pregnancy claims for proper coordination of pay options and return to work dates); (b) any medical, investigative, financial or vocational specialist or entity, or (c) any other organization or person, employed by or representing LifeMap.
- I understand that LifeMap will release information to my employer necessary for return to work and accommodation discussions, and when performing administration for my employer's self-funded (and not insured) disability plans.
- I understand that LifeMap complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to LifeMap may be subject to redisclosure and may no longer be protected under the Health Information Portability and Accountability Act (HIPAA).
- I understand that: (a) I have the right to revoke this authorization by notifying LifeMap in writing, of my revocation; (b) my revocation will not be effective to the extent that a person or entity described above relied on the authorization to disclose information to LifeMap before being notified of my revocation; and (c) although no person or entity described above will condition treatment, payment, enrollment in or eligibility for benefits on me signing the authorization, my revocation of or failure to sign the authorization may affect LifeMap's evaluation of my current disability claim and may be a basis for denying my claim for such benefits.
- I acknowledge that I have read this authorization. I understand and agree that this authorization shall remain in force for the duration of my claim(s) or 12 months, whichever occurs first. A photocopy or facsimile of this authorization is as valid as the original. I understand that I, or my authorized representative, have the right to request and receive a copy of this authorization and the information to which it pertains.

▶ _____ ▶ _____
Employee/Primary Insured's Full Name (please print clearly) Social Security Number

▶ _____ ▶ _____
Employee/Primary Insured's Signature Date Signed

If signature is provided by legal representative (e.g. Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Statement of Short Term Disability

Employer's or Administrator's Statement

Information about Employee

Employee Name (Last, First, Middle Initial)	Job Title	Social Security No	Class	○ Male ○ Female
Employee's Mailing Address Street & Number City State Zip				Employee's Phone Number
Date of Hire	Date Last Actively At Work Before Disability: (Attach payroll records for work activity since disability began)		hours worked that day:	Date of Termination: ☐ N/A

Reason for stopping work: ○ Disability ○ Dismissed ○ Resigned ○ Layoff ○ Retired
○ Family Medical Leave of Absence ○ Other Leave of Absence ○ Other Reason _____

Date returned to work: Full-time: Part-time:	If part-time, number of hours worked per week:	If employee has not returned to work, estimated return to work date:

Are you able to accommodate release to: Reduced hours? ○ Yes ○ No Modified duties? ○ Yes ○ No
If no, please explain:

# of hours regularly scheduled per week:	Please indicate which days of the week this employee is normally scheduled to work. (circle) Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Please describe primary job duties:

Employee's Earnings: $		Is disability due to employment? ☐ Yes ☐ No ☐ Unsure
Earnings prior to increase $	Date of last increase:	
☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ shift differential ☐ bonuses ☐ other:		Has Workers' Compensation claim been filed? ☐ Yes ☐ No ☐ Not yet

Information about Employee's Short Term Disability Coverage

Employee's Short Term Disability Insurance: Insurance Effective Date: Insurance Termination Date:	What percentage of the STD premium does the **Employer** pay? _____% Are employer paid premiums included in employee's salary? ☐ Yes ☐ No ☐ N/A Is **employee** contribution: ○ Pre-Tax Deduction ○ After-Tax Deduction ○ N/A

Other Benefits and Sources of Income

Income Employee is receiving or will receive following last day worked: ☐ None

Type	$ Amount (per week)	Date Began	Date Ended	Type	$ Amount (per week)	Date Began	Date Ended
Sick Pay				PTO / Vacation			
State Disability / Leave				Salary Continuation			
Workers' Compensation				Other (describe):			

Additional Documentation Attached (Please attach a copy of the following documents to this form.)

1. **Employee's current job description**
2. **Employee's Workers' Compensation claim(s) and Approval/Denial Notification, if applicable**

Information about Employer

Employer Name	Location Code (if applicable)	Group Policy Number
Employer Address Street & Number City State Zip		Phone Number
Name and title of employer representative completing this form		Email Address

Acknowledgement

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 6 of this form.

▶ _____ ▶ _____
Employer Representative's Signature Date

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Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to insurance company.

Patient Information

Name of Patient (Last, First, Middle Initial)	Social Security Number	Employer Name

Patient's Mailing Address	City	State	Zip	Patient's Phone Number

Height	Weight	Gender	Date of Birth	Patient Dominant Arm:
		☐ Male ☐ Female		☐ Left-handed ☐ Right-handed

Information about Diagnosis

Diagnosis	ICD Code(s)

Symptoms

Comorbid Conditions

Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings)

Date symptoms first appeared or injury occurred:	Date you recommended the patient stop working on:
Patient's condition is due to: ☐ Illness ☐ Accident	Has patient ever had the same or a similar condition? ☐ Yes ☐ No If Yes, when
Is condition arising out of patient's employment? ☐ Yes ☐ No	Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

Information about Treatment

Date of first visit for this condition:	Date of most recent visit:	Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other	Next office visit:

Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)

Hospital Admission Date:	Hospital Discharge Date:	Was Surgery Performed? ☐ Yes ☐ No	Date of Surgery:
Name of Procedure:		Surgery/Post-Operative Complications: ☐ Yes ☐ No If yes, please describe:	

Was patient treated by another provider(s) for this disability? ☐ Yes ☐ No If Yes, please provide dates, name and address of provider(s):

For Pregnancy Disability Only

Date of Last Menstrual Period	Expected Date of Delivery	Actual Date of Delivery	☐ Vaginal ☐ C-Section

Are there any present complications or anticipated difficulties with: Pregnancy ☐ Yes ☐ No Delivery ☐ Yes ☐ No Post Partum Recovery ☐ Yes ☐ No If "Yes" to any of these, please describe in detail:

Continued on following page.

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Statement of Short Term Disability

Attending Physician's Statement (continued)

Name of Patient (Last, First, Middle Initial)

Assessment of Current Functional Ability

Check the appropriate box indicating frequency your patient could perform the following activities:

	Occasionally, 0%-33%	Frequently, 33%-66%	Continuously, 66%-100%
Bending	☐	☐	☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Pushing/pulling	☐ 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

Describe current restrictions (activities which should not be performed by the patient):

Describe current limitations (activities which cannot be performed by the patient):

Related to a mental health condition, describe behaviors, attitudes or functional impairments that are contributing to the patient's restrictions and/or limitations:

Describe factors delaying recovery (if applicable): ☐ Malingering ☐ Exaggeration ☐ Other, please specify:

Is the patient competent to manage insurance benefits? ☐ Yes ☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

Return to Work Plan

Date you released patient to return to work:	☐ Full Time ☐ Modified Duties ☐ Part Time ☐ Reduced Hours	Number of hours per week:

How long do you expect these limitations and restrictions to impair your patient?

☐ Date _____ ☐ Unable to determine, follow up appointment on_____ ☐ Permanently

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

Information about Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number
Office Address	City State Zip	Fax Number

Acknowledgement

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 9 of this form.

▶ _____ ▶ _____
Attending Physician's Signature Date

Please return completed form to your patient or fax to our office at 1-855-733-4615.

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LifeMap FN V8/14