How To File
SHORT TERM DISABILITY INSURANCE CLAIMS

You've suffered an injury and are unable to work. You're probably stressed and confused. You may be wondering how you'll pay your bills.

Don't worry. Companion Life Insurance Company is here for you. Filing a Short Term Disability Insurance claim is the first step to receiving your benefits. Here's how to file the claim.

At the beginning of the disability period, submit the Short Term Disability and Accident or Sickness Claim form.

You can download the form by logging in to My Online Benefit at CompanionLife.com/insureds. You can also call 877-676-5789 or email CompanionService@CompanionLife.net to request a form.

- You must complete Part I and sign the Authorization To Release Information.
- Have your physician complete and sign Part II.
- Your employer will complete Part III.

Once the form is completed, your employer will submit it to Companion Life for processing.

Completed forms can be emailed to CompanionClaims@CompanionLife.net, faxed to 563-557-3360 or mailed to:

Companion Life

Companion Life Insurance Company | P.O. Box 1535 | Dubuque, IA 52004-1535 | 877-676-5789 | CompanionLife.com

217202-7-2023

Companion Life

DISABILITY INSURANCE CLAIM FORM

P.O. Box 1535
Dubuque, IA 52004-1535
877-676-5789
563-557-3360 (Claims Fax)
CompanionClaims@CompanionLife.net

See Last Pages Companion Life Form 95734 for Fraud Notices

To prevent delays, complete claim in its entirety. Incomplete claims will be returned.

PART I – INSURED INFORMATION

1. **Insured's Name** First / Middle / Last	2. Social Security#	4. Date of Birth Mo. Day Yr.
	3. ID Number	
5. Insured's Address Street / City / State / ZIP		
6. Insured's Sex ☐ Male ☐ Female	7. Job Description and Duties	

8. If disability is due to an accident, did injury occur at work? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

9. I AUTHORIZE ANY PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, DRUG AND ALCOHOL TREATMENT FACILITY, OTHER HEALTH FACILITY, CONSUMER REPORTING AGENCY, THE MEDICAL INFORMATION BUREAU, SOCIAL SECURITY ADMINISTRATION, INSURANCE OR REINSURANCE COMPANY, OR EMPLOYER TO RELEASE ANY AND ALL MEDICAL AND NON-MEDICAL INFORMATION ABOUT ME IN ITS POSSESSION TO COMPANION LIFE INSURANCE COMPANY OR ITS LEGAL REPRESENTATIVES. MEDICAL INFORMATION MEANS ALL INFORMATION IN THE POSSESSION OF OR DERIVED FROM PROVIDERS OF HEALTH CARE REGARDING MY MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, OR TREATMENT. I UNDERSTAND THAT COMPANION LIFE WILL NOT RELEASE ANY INFORMATION OBTAINED TO ANY PERSON OR ORGANIZATION EXCEPT TO REINSURANCE COMPANIES, THE MEDICAL INFORMATION BUREAU, OR OTHER PERSONS OR ORGANIZATIONS PERFORMING BUSINESS OR LEGAL SERVICES IN CONNECTION WITH MY APPLICATION, CLAIM, OR AS MAY BE LAWFULLY PERMITTED, OR AS I MAY FURTHER AUTHORIZE. I KNOW THAT I MAY REQUEST AND RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I AGREE THAT THIS AUTHORIZATION SHALL BE VALID FOR THE DURATION OF MY CLAIM.

SIGNATURE OF EMPLOYEE _____ PHONE NO. _____ DATE _____

PART II – PHYSICIAN INFORMATION

10. Date first treated for this disability Mo. Day Yr.	11. Dates certified disabled and unable to work From: Mo. Day Yr. Thru Mo. Day Yr.	12. If hospitalized, date admitted Mo. Day Yr.

13. Nature of Disability ☐ Accident ☐ Sickness ☐ Maternity (If Accident or Maternity, please complete reverse side of this form.)

14. Diagnosis	15. Diagnosis Code	16. Prognosis

17. **Physical Findings** (*list all test results, or enclose test)*

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Blood Pressure (Systolic) _____ (Diastolic) _____ Date _____

Remarks: _____

TREATMENT

Date of onset of this condition _____ List all dates of treatment for this condition since patient ceased work _____

_____ Date of next office visit _____

Has patient been referred to any other physician? ☐ Yes ☐ No Date(s) _____

If "Yes," name and address _____ Specialty _____

Nature of treatment for this condition *(including surgery/medications)* _____

_____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," date(s) admitted _____ date(s) discharged _____

Name and address of hospital(s) _____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date _____ Procedure _____ CPT Code _____

Progress *(please check one)* ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

18. **IMPAIRMENT**

What are the patient's current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions. (Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity. (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work. (Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity.

What is the psychiatric impairment *(if applicable)*?

☐ Inadequate information to make assessment.

☐ Essentially good functioning in all areas. Occupationally and socially effective.

☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.

☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.

☐ Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.

☐ Inability to function in almost all areas.

Insured's Name First Middle Last Social Security#

DETAILS OF ACCIDENT OR MATERNITY CLAIM – TO BE COMPLETED BY THE PHYSICIAN

19-A. ACCIDENT:

On what date was the patient injured? _____

Where (place) was the patient injured? _____

How was the patient injured? _____

19-B. MATERNITY:

Estimated Date of Delivery (EDC) _____

Prenatal Complications _____

Date of Delivery _____

Postpartum Complications _____

20. I have treated the insured for the condition listed and for the period claimed. The insured has been under my continuous care.

Physician's Name and Address (Please type or print.) _____

Phone No. (Indicate area code.) _____

Date _____

Physician's Signature _____

Has the above patient been released to return to work?

☐ Yes Date to Return (Mo./Day/Yr.) _____

☐ No Approximate Date of Return (Mo./Day/Yr.) _____

☐ No Will not return to work. Disability is total and permanent.

☐ Date of Next Office Visit _____

PART III – EMPLOYER INFORMATION

21. Workers' Compensation: Is there possible Workers' Compensation liability? ☐ Yes (If "Yes," complete this section.) ☐ No

Date accident/sickness reported _____ Date Workers' Compensation claim filed _____

Current status of Workers' Compensation claim: ☐ Approved ☐ Denied ☐ Pending ☐ Not Filed

Name and Address of Workers' Compensation Payment Office _____

22. A. Will employee receive salary continuation, PTO, sick leave, vacation, etc.? ☐ Yes ☐ No

If "Yes," please provide dates from _____ to _____.

B. Is employee subject to child support withholdings? ☐ Yes ☐ No If "Yes," provide appropriate documentation with claim.

23. Is employee enrolled in the Companion Long Term Disability plan? ☐ Yes ☐ No

If "Yes," effective date _____

24. Name and Address of Group	Phone No. and Area Code	25. Group No.

26. I certify that the above insured was a full-time active employee and that he or she did not perform any duties pertaining to his or her occupation during the period claimed in block 11.

Employer's Signature _____ Date _____

Email Address _____

27. First Day Not at Work			28. Date Returned to Work			29. Amount of Weekly Earnings	30. Amount of Weekly Benefit
Mo.	Day	Yr.	Mo.	Day	Yr.		
						$ _____	$ _____

INSTRUCTIONS FOR FILING CLAIM FOR WEEKLY DISABILITY BENEFITS

The reverse of this form should be completed by the insured employee, the employer and the insured's attending physician as soon as possible after the onset of the accident or sickness for which claim is made. If accident or maternity, details must be stated above. If employee is 65 or older, please provide payroll records three months prior to last day worked.

The date we need a doctor's statement of continuing disability will be indicated on the check stub each week. To prevent delays in weekly disability payments, submit the doctor's statement to Companion Life 10 days before this date occurs.

Weekly disability checks are mailed to the member's address.

Please allow three business days from date of receipt for processing. When your employee returns to work, please call our Claims department at 877-676-5789 to notify us immediately and then follow up with the final claim. Notifications can be faxed to: 563-557-3360

PHONE: 877-676-5789 FAX: 563-557-3360

Claims should be forwarded to:

Companion Life Insurance Company
Attention: Claims Department
P.O. Box 1535
Dubuque, IA 52004-1535

By furnishing this blank form and investigating the claim, Companion Life Insurance Company shall not be held to admit the validity of any claim, or to waive or breach any terms or conditions of the policy.

Companion Life

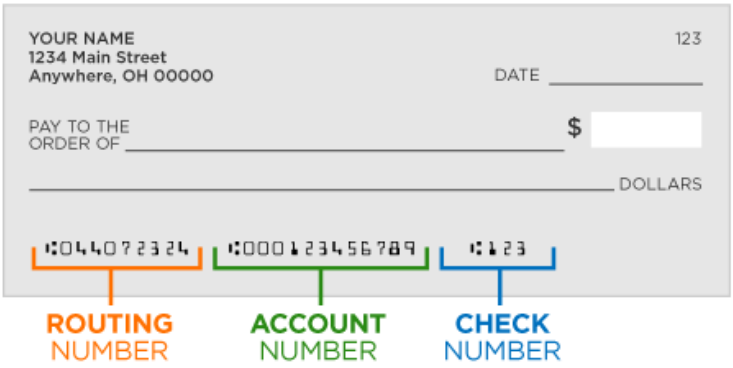
Direct Deposit Authorization Form
For Short Term Disability Insurance Payments

Automatic Direct Deposit is a convenient feature for employees to receive their short term disability insurance claim payment(s). If you decide to take advantage of Automatic Direct Deposit, your check(s) will be deposited automatically into the checking or savings account you provide.

By completing the Authorization Form below and providing a copy of a voided check or savings deposit slip, you are authorizing Companion Life Insurance Company and your financial institution to deposit your short term disability insurance payment(s) into your checking or savings account.

Direct Deposit Form	
Group Name	Group Number
Participant Name	Participant ID
Participant Mobile Phone Number	Participant Email Address
Financial Institution	Financial Institution Phone Number
Financial Institution Address	
Checking/Savings Account Routing # -9 Digits	Checking/Savings Account # 6-13 Digits
Account is a checking or savings account	○ Savings ○ Checking

I hereby authorize Companion Life Insurance Company to deposit short term disability insurance payment(s) directly into my checking or savings account indicated above. I also authorize the financial institution named above to accept my deposit(s) and to credit the amount to my account. This authority will remain in effect until Companion Life has received written cancellation notice from me in such time and such manner as to afford Companion Life a reasonable opportunity to act upon it.



Signature:_____

Date:_____

Please send the completed form and a copy of a voided check or savings deposit slip to Companion Life by faxing to 563-557-3360, mailing to PO Box 1535 Dubuque Iowa 52004-1535, or emailing companionclaims@companionlife.net.

GENERAL FRAUD WARNING: 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.

The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: 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.

Arkansas: 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.

Colorado: 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.

Delaware: 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.

District of Columbia: 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: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: 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.

Massachusetts: 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 or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

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

New Hampshire: ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: 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.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: 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.

Rhode Island: 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.

Tennessee: 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.

Texas: Any person who knowingly presents a 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.

Vermont: 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 may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: 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.

Washington: 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.

West Virginia: 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.