UnitedHealthcare®

Claim Form and Instructions for Group Short Term Disability Employee

Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing your request for benefits.**

As the employee, you are required to include/complete the following documentation (as applicable):

- ☐ Employee Short Term Disability Statement
- ☐ Employee's Disclosure Authorization
- ☐ Employee's Authorization of Personal Representative *(if applicable)*
- ☐ Providing Attending Physician's Statement to the physician(s) treating you
- ☐ Provide a copy of the completed Employee's Disclosure Authorization
- ☐ Attach any copies of Social Security, Workers' Compensation, Retirement or any other income benefit awards and/or denials *(if applicable)*

Completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits:

Mail:
UnitedHealthcare Specialty Benefits
PO Box 7466
Portland, ME 04112-7466

Email (email is unsecured unless you are a registered Cisco user):
FPCustomerSupport@uhc.com

Fax:
888-505-8550

Phone:
888-299-2070

General Demographics

Employee's Full Name (first, middle initial, last)			Social Security Number
Street Address	City	State	ZIP Code
Phone Number	Date of Birth	Height	Weight	Gender M F
Marital Status Single Married Divorced Widowed			Is Spouse Employed? Yes No
If married, Spouse's First and Last Name			Spouse's Date of Birth
Employee's Dependent Name(s)			Date(s) of Birth

Employer's Name (include division if applicable)	Employer's Phone Number

Employment and Claim Information

Date of hire	Date you first noticed symptoms of illness/injury	Date last worked (physically)? Hours worked that day? What date do you expect to return to work?

When were you first treated for your injury or illness?	Have you ever had the same or similar condition in the past? Y N If yes, when?	Have you returned to work? Y N Date you returned-Part Time Date you returned-Full Time

Your occupation (list job duties)	What parts of your job are you unable to do?

Please describe the onset and nature of your illness or injury

Is your claim a result of: Illness Accident	If accident, please provide the date and type of accident: Date Type

Was your injury or illness due to an auto accident? Y N If yes, have you filed an auto insurance claim? Y N	If yes, provide auto carrier name/address/phone number
Were you injured at work? Y N If yes, date of injury Was Workers' Compensation claim filed? Y N	Workers' Compensation carrier/contact name/phone number

Please provide the name, address and date you first saw the physician(s) who is/are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.

Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? Y N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? Y N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? Y N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? Y N

Benefits and Earnings Information

Are you receiving/ have you applied for any of the following benefits (include benefits for you or any family member)? Please provide copies of any decisions, including denial and/or award notices for any benefits noted below.

Type of Benefit	*Applied for or appealed? State if pending*	*Benefit Amount*	*Payment Frequency*	*Benefit Coverage Dates (MM/DD/YY)*
Salary Continuance		$	Wkly Mthly	From: Through:
Social Security Disability /Retirement		$	Wkly Mthly	From: Through:
Family/Dependent Social Security Disability		$	Wkly Mthly	From: Through:
State Disability		$	Wkly Mthly	From: Through:
Sick Pay		$	Wkly Mthly	From: Through:
Unemployment		$	Wkly Mthly	From: Through:
Vacation/PTO		$	Wkly Mthly	From: Through:
Auto No Fault		$	Wkly Mthly	From: Through:
Pension or Retirement		$	Wkly Mthly	From Through:
Other Sources of Income		$	Wkly Mthly	From Through:

Please list name and contact info for any of the "other" sources of income checked off:

Name Contact Information

If applied for any of the above benefits, please give additional details here:

Are you receiving, have previously received or applied for any type of payment from any employer's retirement member plan? Y N	If yes, provide employer name/address/phone number

Tax Information

If your request for benefits is approved, do you want the minimum $20.00 per week withheld from your check for Federal Income Tax purposes? Y N	If you would like more than $20.00 withheld per week, please state the whole dollar amount you want withheld weekly. Amount $ (minimum amount per week is $20.00)

Final Signature and Certification

The above statements are true and complete to the best of my knowledge and belief.
I acknowledge that I have read the applicable Fraud Warning Notice provided with this claim form.

Name of person completing this form	Phone Number
Signature (eSignature is allowed)	Date Signed

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

DISCLOSURE AUTHORIZATION **TO BE COMPLETED BY EMPLOYEE**

Participant's Name (Please Print):_____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 12 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

PLEASE SIGN AND DATE IN INK

Relationship, if other than Claimant: _____

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

(Rev. 06/18)

AUTHORIZATION OF PERSONAL REPRESENTATIVE **TO BE COMPLETED BY EMPLOYEE**

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my disability claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/_____

Signature: _____

PLEASE SIGN AND DATE IN INK

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