Colonial Voluntary Benefits™   Continuing Disability Claim

⬆ FAX this direction	**FAX this form: 1-800-880-9325** Or mail: P.O. Box 100195, Columbia, SC 29202	From:
		Number of pages:

Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Paul Revere to facilitate processing this claim by releasing its details to the following individual(s) inquiring on my behalf. **Note: Leave blank if you do not want anyone accessing your claim information.**

_____ Sales representative   _____ Employer   _____ Spouse, family member or significant other Name: _____

_____ I want Paul Revere to update me on the status of my claim through prerecorded messaging at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your phone.

_____ **Yes, I want ALL payment(s) for this claim sent by overnight delivery.** I understand payment(s) under $100.00 cannot be sent overnight. I also understand that if I want my claim to be sent by overnight delivery, a **$22.00 fee** will be deducted from my claim payment. This fee is subject to rate increases by carrier and does not include weekend delivery. **I understand that Paul Revere is unable to send overnight mail to a P.O. Box.**

I also understand that I must notify Paul Revere to discontinue discontinue any of these services.

Do not use this form if filing for injury or sickness for the first time.

Complete each section before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim.

- Benefits are payable to you unless we receive written authorization to pay them elsewhere. This is called an assignment.

- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

Section 1 – Claimant statement (completed by policy owner)

Claimant name:	☐ Male ☐ Female	DOB: ____ / ____ / _____	SSN:

Relationship to policy owner: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent

Policy owner information (if other than claimant)	Name:		DOB: ____ / ____ / _____	SSN:
Address:		City:	State:	ZIP:
Email:		Contact number:		

Claim is for: ☐ Accident ☐ Sickness   Date the accident occurred (not when it was treated): _____ / _____ / _____

Condition that keeps you from working:

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming require the following statement to appear on this claim form.

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

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: 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: 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: 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.

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.

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 RSA 638.20.

New Jersey: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and civil penalties.

New York: 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 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.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present; it may be reduced to a minimum of two (2) years.

Claimant name:	Claimant SSN:

Section 1 – Claimant statement ~ continued (completed by policy owner)

Have you been unable to work?: ☐ Yes ☐ No If yes, list the dates unable to work: From: _____ / _____ / _____ To: _____ / _____ / _____

Date returned to work: Full-time: _____ / _____ / _____ Part-time: _____ / _____ / _____ Hours worked per week: _____

If not employed

List dates of house confinement: From: _____ / _____ / _____ To: _____ / _____ / _____
House confinement means you are kept at home (in house or yard) by the condition. However, you may follow physician's orders, even if it means leaving home.

Have you been unable to perform activities of daily living? ☐ Yes ☐ No If yes, list dates: From: _____ / _____ / _____ To: _____ / _____ / _____

Check activities of daily living that you are unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence

Certification

Policy owner's name: _____ SSN: _____

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page two of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form.

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the 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 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.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Physician Statement portion of the claim form.

_____ _____ _____
Print claimant's name   Claimant's signature   Date

_____ _____ _____
Print policy owner's name   Policy owner's signature   Date

Section 2 – Employer statement (completed by employer)

Employee name:	Employee title:
Was the employee at work when accident or sickness occurred? ☐ Yes ☐ No	Was a workers' compensation claim filed? ☐ Yes ☐ No
Workers' compensation carrier:	Telephone:

Employee unable to work (Full-time): From:_____ / _____ / _____ To: _____ / _____ / _____

Expected return to work: _____ / _____ / _____	Actual return to work Full-time: _____ / _____ / _____	Actual return to work Part-time: _____ / _____ / _____ Hours per week:_____

Contact for updates on return to work status:

Telephone:	Email:

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes employer's portions of the claim form.

_____ _____
Signature of authorized person   Date (MM/DD/YYYY)

Title of authorized person signing:		Employer/company name:
Telephone:	Fax:	Email:

Claimant name:	Claimant SSN:

Section 3 – Physician statement (completed by physician)

Patient name: DOB: _____ / _____ / _____

Is condition due to an accidental injury? ☐ Yes ☐ No

What diagnosis prevents the patient from working? (If pregnancy, list complications.)

Date first treated for this diagnosis: _____ / _____ / _____

Are there any secondary diagnoses preventing the patient from working? ☐ **Yes** ☐ **No** Secondary diagnoses:

When did symptoms first appear? _____ / _____ / _____

Date of new patient consultation: _____ / _____ / _____

Symptoms:

Current treatment plan:

List any test performed (submit copy of test results):
Date: _____/ _____/ _____ CPT code: _____
Date: _____/ _____/ _____ CPT code: _____

List any surgeries performed (submit copy of operative report):
Date: _____/ _____/ _____ CPT code: _____
Date: _____/ _____/ _____ CPT code: _____

Date of patient's last visit: _____ / _____ / _____

Date of next scheduled visit: _____ / _____ / _____

How soon do you expect significant improvement in the patient's medical condition?
☐ 1 - 2 months ☐ 3 - 4 months ☐ 5 - 6 months ☐ more than 6 months

Does patient have permanent restrictions and/or limitations? ☐ **Yes** ☐ **No**
If yes, which ones are permanent:

Limitations (patient CANNOT DO):

Restrictions (patient SHOULD NOT DO):

Dates unable to work (full-time): From: _____ / _____ / _____ To: _____ / _____ / _____

Expected return to work: _____ / _____ / _____

Dates able to work (part-time):
From: _____ / _____ / _____ To: _____ / _____ / _____ Number of hours: _____

Actual return to work (full time): _____ / _____ / _____

Did this condition require house confinement?: ☐ Yes ☐ No If yes, From: _____ / _____ / _____ To: _____ / _____ / _____
House confinement means the patient is kept at home (in house or yard) by the condition. However, the patient may follow your orders, even if it means leaving home.

Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence

Dates unable to perform activities of daily living: From: _____ / _____ / _____ To: _____ / _____ / _____

Date(s) of hospitalization (last 3 months):

Date(s) of office visit (last 3 months):

Have you referred patient to a specialist? ☐ **Yes** ☐ **No**

Hospital:			Specialist:		
Address:	State:	ZIP:	Address:	State:	ZIP:
Telephone:	Fax:		Telephone:	Fax:	

PREGNANCY Date of delivery: _____ / _____ / _____ Type of delivery: ☐ Vaginal ☐ C-section

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

_____
Physician signature

_____
Date (MM/DD/YYYY)

Physician/group name:		Patient account number:	
Physician's specialty:	Telephone:		Fax:
Address:	City:	State:	ZIP:
Tax ID or SSN:	Do you accept medical record requests by fax? ☐ **Yes** ☐ **No**		

Do you require a special authorization for release of information? ☐ **Yes** ☐ **No** Will you accept the standard HIPAA release? ☐ **Yes** ☐ **No**

Was patient referred to you by another physician? ☐ **Yes** ☐ **No** Authorization on file to release information to Paul Revere: ☐ **Yes** ☐ **No**

Referring physician:		Telephone:		Fax:	
Address:	City:		State:		ZIP: