UNICARE®

Long Term Disability
Notice of Claim Package

Employer Notice Of Claim - Instructions

At approximately 30 days before end of benefit waiting period:

A. Complete the Employer's Report of Claim in full.

Include • Job description *(detailed duties, including physical requirements)*
• Documentation of earnings in accordance with your plan description
• Worker's Compensation information *(copy of first report of accident and the decision if any has been determined at this time)*

B. Give remaining part form to claimant for completion. These forms should be forwarded to the address shown below.

Request • Copy of awards from other source of benefits: Social Security, Worker's Compensation Retirement, State Disability, No-fault auto insurance and any other disability income.
• That the employee forward proof of his / her age.

C. If claimant has more than one treating physician, give claimant additional forms for completion.

D. All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

E. Any questions about these claim filing procedures should be referred to:

UNICARE
LTD CLAIMS UNIT
P.O. BOX 105426
ATLANTA, GA 30348-5426

For Customer Service Call: 800-232-0113
For Customer Service Fax: 800-850-0017

UNICARE®

Long Term Disability
Employer's Report of Claim

Claimant

1. EMPLOYEE'S NAME				2. SOCIAL SECURITY NUMBER		3. DATE OF BIRTH
4. ADDRESS	CITY		STATE	ZIP CODE		5. PHONE NUMBER
6. POLICY NO.	7. BILLING UNIT	8. CERTIFICATE NO.	9. INSURANCE CLASS	10. EMPLOYEE DATE OF HIRE	11. EFFECTIVE DATE OF LTD	12. DATE EMPLOYEE LAST WORKED FULL TIME

Employment

13. OCCUPATION AT TIME LAST WORKED (Attach Job Description)

14. WORK SCHEDULE AT TIME LAST WORKED

No. of days per week _____ No. of hours per day _____

15. REASON FOR LEAVING WORK

☐ Sickness ☐ Granted LOA ☐ Laid Off
☐ Retired ☐ Dismissed ☐ Other
☐ Resigned ☐ Vacation

16. HAS EMPLOYEE RETURNED TO WORK?

☐ Yes ☐ Part-time ☐ Full-time

☐ No Date _____ Date _____

Income

17. HOW IS EMPLOYEE PAID?

☐ Straight Salary ☐ Hourly
☐ Salary & Commissions ☐ Salary & Bonus
☐ Commissions Only

18. EMPLOYEE'S BASIC MONTHLY EARNINGS

$ _____ LTD Benefit _____

(If salary is based on less than 12 mos. - No. of mos. _____

19. EMPLOYEES PERCENT OF LTD PREMIUM CONTRIBUTION

Employee Pays _____ Employer Pays _____

Other Benefits

20. HAS INSURED RECEIVED OTHER DISABILITY PAYMENTS SINCE TIME LAST WORKED?

Salary Continuance:	Insured Short Term:	Other Type: _____
☐ Yes *(Weekly Amount)* _____	☐ Yes *(Weekly Amount)* _____	☐ Yes *(Weekly Amount)* _____
Date Benefits Cease _____	Date Benefits Cease _____	Date Benefits Cease _____
☐ No	☐ No	☐ No

21. DID CLAIM RESULT FROM JOB ACTIVITY?

☐ Yes *(Explain)* ☐ No

22. HAS WORKER'S COMPENSATION CLAIM BEEN FILED?

☐ Yes ☐ Denied *(Enclose Copy)*
☐ Pending

23. WORKER'S COMPENSATION WEEKLY AMOUNT

$ _____

(Include copy of 1st report of accident)

Retirement

24. IS EMPLOYEE COVERED BY EMPLOYER SPONSORED RETIREMENT PLAN?

☐ Yes ☐ No

25. DOES RETIREMENT PLAN CONTAIN A DISABILITY PROVISION?

☐ Yes ☐ No

26. IS EMPLOYEE OR WILL THIS EMPLOYEE BE ELIGIBLE FOR A DISABILITY OR RETIREMENT PENSION?

☐ Yes If "Yes," type Monthly Amount $ _____ ☐ Disability ☐ Retirement Other _____
☐ No Date Benefits Commence _____
(Enclose copy of summary plan description)

Note: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his / her contribution to the total contribution.

(Continued on Reverse Side)

Certification

27. EMPLOYER'S NAME	28. EMPLOYER'S TELEPHONE NUMBER	29. CERTIFICATE NUMBER

30. ADDRESS

31. EMPLOYER *(Taxpayer) I.D. Number (EIN)* _____ - _____ OR 32. PUBLIC EMPLOYER SOCIAL SECURITY NO. 69 _____ - _____	33. NAME OF PERSON COMPLETING THIS FORM (Please type or print)	
34. SIGNATURE OF AUTHORIZED INSURANCE REPRESENTATIVE ▶	TITLE	DATE

Separate and send this form (with other enclosures) to the address shown on the front page. Give the remaining forms to the claimant.

UNICARE®

Long Term Disability
Employee's Disability
Benefits Application

Claimant

1. FULL NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER	3. PHONE NUMBER

4. ADDRESS	CITY	STATE	ZIP CODE

5. DATE OF BIRTH (Mo, Day, Yr)	6. HEIGHT	7. WEIGHT	8. SEX	9. MARITAL STATUS	10. SPOUSE'S DATE OF BIRTH (Mo, Day, Yr)	11. IS SPOUSE EMPLOYED?
			☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced	First Name	☐ Yes ☐ No

12. NUMBER OF CHILDREN (Under age 19)	13. LIST NAMES AND DATES OF BIRTH OF UNMARRIED CHILDREN WHO HAVE NOT YET FINISHED HIGH SCHOOL

14. EMPLOYER'S NAME	15. GROUP POLICY NO.	16. LEVEL OF EDUCATION *(Please check proper box)*			Degree Received
		High School / Grade	College	Graduate	
		1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4	1 2 3 4	

Employment

17. OCCUPATION *(List the duties of your occupation at the time of disability)*

18. DATE OF ACCIDENT OR DATE FIRST NOTICED SYMPTOMS OF ILLNESS (Mo, Day, Yr)	19. I HAVE BEEN UNABLE TO WORK BECAUSE OF THE DISABILITY SINCE (Mo, Day, Yr)	20. I RETURNED TO WORK ON A PART TIME BASIS ON: (Mo, Day, Yr)	21. I RETURNED TO WORK ON A FULL TIME BASIS ON: (Mo, Day, Yr)

22. IS YOUR ACCIDENT OR ILLNESS RELATED TO YOUR OCCUPATION?	23. IF "YES" EXPLAIN
☐ Yes ☐ No	HAVE YOU OR DO YOU INTEND TO FILE A WORKERS' COMPENSATION CLAIM? ☐ Yes ☐ No

Claim History

24. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED OR DESCRIBE THE ONSET AND NATURE OF YOUR ILLNESS.

☐ Auto ☐ Work
☐ Home ☐ Other

25. DATE YOU WERE FIRST TREATED FOR THIS ILLNESS OR INJURY. (Mo, Day, Year)	26. TREATED BY:
	Hospital Name: _____ Street Address _____ City _____ State _____ Zip Code _____ Doctor: _____ Street Address _____ City _____ State _____ Zip Code _____

27. HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST. (If yes, complete No. 28) ☐ Yes ☐ No	28. TREATED BY:
	Hospital Name: _____ Street Address _____ City _____ State _____ Zip Code _____ Doctor: _____ Street Address _____ City _____ State _____ Zip Code _____

(Continued on Reverse Side)

Income

29. DESCRIBE OTHER INCOME YOU ARE RECEIVING:

Yes	No		amount	date began	date term.
☐	☐	Social Security (disability or retirement)	$		
☐	☐	State disability	$		
☐	☐	Retirement (normal, early or disability)	$		
☐	☐	Workers' Compensation	$		
☐	☐	Group disability benefits	$		
☐	☐	Other (describe) _____	$		

Benefit

30. HAVE YOU, OR DO YOU PLAN TO APPLY FOR ANY BENEFIT(S) DESCRIBED ABOVE:

☐ Yes ☐ No

Type _____ Date application filed _____

Type _____ Date application filed _____

31. IF YOUR REQUEST FOR BENEFITS IS APPROVED DO YOU WANT US TO WITHHOLD AMOUNTS FROM EACH BENEFIT CHECK FOR **FEDERAL INCOME TAX** PURPOSES?

☐ Yes ☐ No

If "Yes," Amount $ _____ *(Indicate amount per week, $20.00 min.)*

32. IF YOUR REQUEST FOR BENEFITS IS APPROVED DO YOU WANT US TO WITHHOLD AMOUNT FROM EACH BENEFIT CHECK FOR **STATE TAX** PURPOSES?

☐ Yes ☐ No

If "Yes," Amount $ _____ *(Indicate amount per week, $20.00 min.)*

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false or misleading information may be subject to criminal penalties.

The above statements are true and complete to the best of my knowledge and belief.

SIGNATURE OF EMPLOYEE	DATE

UNICARE®

Long Term Disability
Employee Authorization for Release of Information

Authorization to be completed by claimant

To Whom It May Concern:

I, _____ , hereby authorize any hospital, physician medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company, Government Agency including but not limited to the Social Security Administration, to disclose or furnish to UniCare Life & Health Insurance Company or its authorized representative, any and all information with respect to: any illness or injury including mental illness, drug / alcohol abuse, medical history, consultations, prescriptions, treatments or benefits and copies of all records that may be requested.

In addition, I authorize any employer, statutory employer, business or individual that paid me for services rendered, including but not limited to, business associate(s), insurance company, Government Agency including but not limited to the Social Security Administration, educational institute, consumer reporting agency, accountant, and / or other individuals to disclose to UNICARE, or its authorized representative any and all information with respect to: work history, occupational requirements, educational history, wages, commissions, financial and corporate agreements and arrangements, benefits, insurance claims, and coverage.

The information provided to UNICARE, or its authorized representative is to be used for the evaluation and administration of my claim(s) with UNICARE or any of its affiliates. A photocopy of this authorization is to be considered as valid as the original and both are effective for one year from the date this authorization was signed.

CLAIMANT'S SIGNATURE	CLAIMANT'S SOCIAL SECURITY NUMBER	DATE
	RELATIONSHIP OF AUTHORIZED PERSON	

NOTE: A true copy of this authorization is available to the claimant or his authorized representative at any time, upon request.

Send Completed Form To:

UNICARE
LTD CLAIMS UNIT
P.O. BOX 105426
ATLANTA, GA 30348-5426

UNICARE®

Long Term Disability
Attending Physician's Statement

History

NAME OF PATIENT | DATE OF BIRTH

(A) WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	(B) DATE PATIENT CEASED WORK BECAUSE OF DISABILITY?	(C) HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ Yes If "Yes, state when and describe ☐ No
(D) IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No ☐ Unknown	(E) NAMES AND ADDRESSES OF OTHER TREATING PHYSICIANS	

Diagnosis (If disabling condition is due to a mental or nervous disorder, the attached Functional Capacities and Mental Status Supplemental Questionnaire must also be completed.)

(A) DIAGNOSIS (INCLUDING COMPLICATIONS)	(B) IF PREGNANCY, EST. DATE OF DELIVERY	(C) SUBJECTIVE SYMPTOMS

(D) OBJECTIVE FINDINGS *(Including current x-rays, EKG's laboratory data and any clinical findings)*

Treatment

(A) DATE OF FIRST VISIT	(B) DATE OF LAST VISIT	(C) FREQUENCY ☐ Weekly ☐ Monthly ☐ Other (Specify)

(D) NATURE OF TREATMENT (INCLUDING SURGERY AND MEDICATIONS PRESCRIBED, IF ANY)

Progress

(A) HAS PATIENT ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?	(B) IS PATIENT ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?	IS PATIENT MENTALLY COMPETENT TO ENDORSE CHECKS AND DIRECT PROCEEDS THEREOF? ☐ Yes ☐ No

(C) HAS PATIENT BEEN HOSPITAL CONFINED *(If yes, give Name and Address of Hospital)*

☐ Yes ☐ No Confined from _____ through _____

Cardiac

(A) FUNCTIONAL CAPACITY (AMERICAN HEART ASSOCIATION) ☐ Class 1 (No limitations) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)	(B) BLOOD PRESSURE *(last year)* _____ systolic/diastolic

Impairments

(A) PHYSICAL IMPAIRMENTS (*As defined in Federal Dictionary of Occupational Titles)

☐ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions, (0-10%)
☐ Class 2 - Medium manual activity* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical / administrative (sedentary*) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

Remarks Please use the reverse side of this form.

(Continued on Reverse Side)

Impairments (Continued)

(B) MENTAL IMPAIRMENTS *(if applicable)*

(a) Please define "stress" as it applies to this claimant and in light of his/her job requirements.

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations *(no limitations)*
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations *(slight limitations)*
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations *(moderate limitations)*
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations *(marked limitations)*
- ☐ Class 5 - Patient has significant loss of psychological, physiological personal and social adjustment *(severe limitations)*

Prognosis

(A) IS PATIENT NOW TOTALLY DISABLED? *(Unable to be Gainfully Employed)*	(B) DATE PATIENT BECAME DISABLED DUE TO PRESENT ILLNESS
Patient's Job ☐ Yes ☐ No Any Other Work ☐ Yes ☐ No	

(C) WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE FUTURE?

☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ Never Applies To: ☐ Patient's Job ☐ Other Work

Rehab

(A) IS PATIENT A SUITABLE CANDIDATE FOR OCCUPATIONAL REHABILITATION?	Patient's Job ☐ Yes ☐ No	Any Other Work ☐ Yes ☐ No	(B) CAN PRESENT JOB BE MODIFIED TO ALLOW FOR HANDLING WITH IMPAIRMENT? ☐ Yes ☐ No

(C) WHEN COULD TRIAL EMPLOYMENT COMMENCE?

Date _____ Patient's Job ☐ Full-time ☐ Part-time

Date _____ Any Other Work ☐ Full-time ☐ Part-time

Remarks

LIMITATIONS, THERAPY, *(etc)*

NAME OF ATTENDING PHYSICIAN *(Please Type or Print)*	DEGREE	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

SIGNATURE	DATE

UNICARE®

Long Term Disability
Supplemental Attending Physician's Statement

Mental Status Questionnaire

(Only needs to be completed if condition is due to a mental or nervous disorder.)

PATIENT NAME

DATE TREATMENT BEGAN	CONTINUING	TERMINATED
Month Day Year	☐ Yes ☐ No	Month Day Year

DIAGNOSIS (Use DSM III Multi axial evaluation nomenclature and code numbers.)

I
II
III
IV
V

Please respond to all items. Use additional pages as necessary

State patient's initial reason for seeking treatment. Describe how and when the condition was first manifested. Summarize previous treatment testing. If any.

Describe patient's current condition and mental status. Include the duration and severity impairments and stress factors.

Medications: Please list current medications, dosage and dates begun, as well as existing or possible side effects.

Duration and Treatments: Please summarize current treatment goals and estimated duration of treatment to achieve stated goals.

Comments:

Functional Capacities Evaluation

Based on your evaluation of the claimant's psychiatric status, please give your opinion as to the extent of the claimant's ability to do the following on **a sustained** basis.

None: No impairment in this area.
Mild: Suspected impairment of slight importance which does not affect functionality ability.
Moderate: Impairment affects but does not preclude ability to function.
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

1. Ability to relate to other people.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
2. Restriction of daily activities, e.g. ability to attend meetings, socialize with others, attend to personal needs, etc.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
3. Deterioration of personal habits.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
4. Constriction of interests	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
5. Understand, carry out, and remember instructions.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
6. Respond appropriately to supervision.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
7. Perform work requiring regular contact with others.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
8. Perform work where contact with others will be minimal.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
9. Perform tasks involving minimal intellectual effort.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
10. Perform intellectually complex tasks requiring higher levels of reasoning, math and language skills.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
11. Perform repetitive tasks.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
12. Perform varied tasks.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
13. Makes independent judgement.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
14. Supervise or manage others.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
15. Perform under stress when confronted with emergency, critical, unusual or dangerous situations; or situations in which working speed and sustained attention are make or break aspects of the job.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe

Physician's Signature

Date