Rapid Pay Income Replacement℠ Claim Form Instructions

EPIC's Rapid Pay Claim Form has three sections – you (the employee), your employer, and your attending physician(s) must each complete your corresponding section. **Immediately AFTER the date your disability begins, please submit completed Employee and Employer Questionnaires.** Review of your claim for advance payment will begin upon receipt of the Employee and Employer Questionnaires. Your physician(s) will need to complete and return the *Attending Physician Statement(s)* before a claim determination can be made.

Section I | *Employee Questionnaire*

This questionnaire is to be completed by the employee applying for Rapid Pay Income Replacement benefits. The Federal Income Tax Withholding Form and General Right of Recovery and Reimbursement Agreement form also need to be completed by the employee.

Section II | *Employer Questionnaire*

This questionnaire is to be completed by the employer's authorized representative.

Section III | *Attending Physician Statement*

This statement is to be completed by the employee's attending physician(s). We recommend that any medical records and/or test results that support the claimed disability be submitted with the *Attending Physician Statement*.

Helpful Hints Regarding Your Claim

- If you have multiple physicians treating you for your claimed disabling condition, **EACH** physician will need to complete an *Attending Physician Statement.*
- If your claim is related to an injury, please provide specific details about the incident along with any police or accident reports.
- Consult your tax advisor or group leader before completing the Federal Income Tax Withholding Form.
- If your claim will be due to a scheduled surgery, you may submit your claim prior to the surgery.

Submitting Your Claim

Please mail or fax the completed, signed claim forms and any supporting documentation to:

The EPIC Life Insurance Company
Attention: Rapid Pay Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
Fax: 608-223-2159

Questions/Assistance

For questions or assistance, please contact EPIC's Claim Department at 800-520-5750 or e-mail us at claims@epiclife.com.

General Right of Recovery Notice and Reimbursement Agreement

Rapid Pay Income Replacement^{sm} Advance Payment

The EPIC Life Insurance Company (EPIC) utilizes a Rapid Pay Short Term Disability (STD) procedure for certain, eligible claims. Part of the Rapid Pay procedure is to issue an advance payment on eligible claims that are anticipated to be approved. Payment under the Rapid Pay procedure does not constitute approval of the claim. If EPIC issues an advance payment and at a later date, determines that your initial application for STD benefits is not payable, you will be responsible for remitting the advance payment in full, pursuant to your policy's General Right of Recovery provision (see below). EPIC will not request that you remit the advance payment if your claim is initially approved (confirmed by receipt of a written notice of approval), payments are made and then terminated at a later date.

General Right of Recovery

If we pay any monies or benefits that are not due or payable under the policy, including, but not limited to, benefits paid in error by us, we have the right to be repaid to the full extent of such overpayment. We shall be repaid to the full extent of such overpayment. We can recover such excess payments from any person, organization or institution to, for, or with respect to whom such monies were paid by us. If we cannot recover such excess payments from any other source, we can recover them from you or any of your dependents. When we request that you pay us an amount of the excess payments, you agree to pay us such amount immediately upon our notification to you. We may, at our option, reduce any future payments for which we are liable under the policy by the amount of the excess payments, in order to recover such payments.

We will reduce such benefits otherwise payable until the excess payments are recovered by us. Our rights of recovery under this subsection are in addition to any rights we have under common law with respect to such overpayment.

Agreement

I hereby agree to reimburse EPIC for any and all advance payment(s) made to me under the Claim/Policy listed below if my initial application for STD benefits is not approved. I agree to remit the entire advance payment amount upon receipt of notice, regardless of whether I decide to appeal the decision.

____

Claimant Name (please print)

____

Claimant Signature

____

Date

For Office Use Only

Claim #: ________________________

Policy #: ________________________

Short-Term Disability Claim Form

Employee Questionnaire

1. Name	2. Date of Birth
3. Street Address	4. Telephone
5. City State Zip	6. E-mail Address
7. Group Number & Division	8. Certificate Number and Social Security Number (required for tax purposes)
9. Current job title with your employer	10. What is the first date you were unable to work because of this disability?

11. Describe the daily duties of your job (Example: My job requires that I am kneeling/squatting 80% of the day and the remaining 20% walking or sitting.)

12. Have you been continuously totally disabled? ❑ Yes ❑ No If no, what date did you return to work? ❑ Full-Time ❑ Part-Time

13. Have you been continuously partially disabled? ❑ Yes ❑ No If no, what date did you return to work?

14. Describe your medical condition.

15. Did you use sick time or vacation time? ❑ Yes ❑ No If yes, what were the specific dates of sick or vacation time used?

16. Is this disability injury related? ❑ Yes ❑ No **If yes, please describe how, when and where the injury occurred.**

17. Did your illness or injury occur as a result of engaging in any activity for pay, profit or gain? ❑ Yes ❑ No
If yes, please provide the name and address of the employer where the illness or injury occurred.

18. If your claim was approved or denied by the workers compensation carrier, **please provide a copy of the approval or denial letter with your claim.**

19. Are you receiving any income(s)? ❑ Yes ❑ No
If yes, please provide the following information:

A. Social Security Disability Income: $___________________

B. Workers Compensation Income: $___________________

C. Other incomes (including incomes from other insurance policies):$______________________

D. If you are receiving any income, please provide the names and addresses, policy number and the date payments began and/or ceased?

____

____

20. Prior to this disability claim, did you receive a diagnosis, medical care, services, treatment, advice or recommendations for this disability? ❑ Yes ❑ No

If yes, please provide the following dates:

A. Diagnosis ____ D. Treatment ____

B. Medical Care ____ E. Advice ____

C. Services ____ F. Recommendations ____

21. Please provide the names, addresses and telephone numbers of your family physician and other treating physicians.

____

____

____

FEDERAL INCOME TAX WITHHOLDING - Not Applicable When the Employee Pays 100% of the Premium (Voluntary Plan)

22. If you would like EPIC to withhold Federal Income Tax from your available disability benefit, please complete a **Federal Income Tax Withholding Form**.

    Note for Self-funded Plans: If your employer is funding your short-term disability plan, EPIC is required by law to withhold Federal Income Taxes at a rate of 28% of your gross benefit.

AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION
(This Authorization complies with the HIPAA Privacy Rule)

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Life"). "Information" may include my entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Life to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Life.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Life. I am aware that my revocation will not be effective until received by EPIC Life and will not be effective regarding the uses and/or disclosures of my Information that EPIC Life has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Life with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Life from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

I certify that the information I have provided on this form is true, complete, and accurate to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss may be subject to imprisonment, fines, denial of insurance, and/or civil damages.

Name of Claimant ______________________ Claimant's Date of Birth ______________________

Signature of Claimant or Personal Representative* ______________________ Date Signed ______________________

*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation)

MAIL OR FAX FORM TO: THE EPIC LIFE INSURANCE COMPANY
ATTN: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-223-2159

Federal Income Tax Withholding Form

Not Applicable to Voluntary Plans

Please complete this form if you would like EPIC to withhold Federal Income Taxes from your benefit payments. EPIC recommends that you discuss this option with your tax advisor or group leader to ensure you are making the best decision based on your premium contribution. The minimum amount you may request to withhold is $20 per week.

I am requesting The EPIC Life Insurance Company to withhold $_________ per week from my available disability benefit payments for my Federal Income Taxes. I understand that my request is valid for the duration of my claim or 7 days after EPIC receives my written request for a change or discontinuance.

Note for Self-funded Plans: If your employer is funding your short-term disability plan, EPIC is required by law to withhold Federal Income Taxes at a rate of 28% of your gross benefit.

______________________________ ______________________________

Name of Claimant Claimant's Date of Birth

______________________________ ______________________________

Signature of Claimant or Personal Representative Date Signed

MAIL OR FAX FORM TO: THE EPIC LIFE INSURANCE COMPANY
ATTN: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-223-2159

Short-Term Disability Claim Form

Employer Questionnaire

1. Employee Name

2. Employee Certificate Number

3. Policy Number

4. Date of Hire

5. What was the last day worked and number of hours worked that day?

6. A. Was sick time paid? ❑ Yes ❑ No If yes, please provide date(s) paid. ______________________

   B. Was vacation time paid? ❑ Yes ❑ No If yes, please provide date(s) paid. ______________________

   C. Was salary continuation paid? ❑ Yes ❑ No If yes, please provide date(s) paid. ______________________

7. Did the sickness or injury arise out of or in the course of employment? ❑ Yes ❑ No
   If yes, has a workers compensation claim been filed? ❑ Yes ❑ No
   If yes and the claim was denied by your workers compensation carrier, **provide a copy of the DENIAL letter with this claim.**
   If no, please explain

8 . Is the employee back to work? ❑ Yes ❑ No ❑ Full-Time ❑ Part-Time
   If yes, please provide the return to work date and copy of physician's return to work notice.

9. If employee is partially disabled, are you able to make reasonable accomodations? ❑ Yes ❑ No
   (example: an employee's job requires daily lifting and carrying of objects in excess of 25 lbs. If the physician releases the employee to return to work with a restriction of lifting and carring a maximum of 10 lbs. for 3 weeks, can you reasonably accommodate this restriction?)

   Note: If you have partial disability coverage and the employee returned to work part-time, you must include the number of hours and days worked as well as the earned wages during the week. This information MUST be sent, faxed or emailed to EPIC at the end of each week.

10. Employee's average weekly wage?

11. Employee's average hours per week?

12. Was the employee insured under your prior STD policy? ❑ Yes ❑ No
    If yes, what was the employee's effective date of the prior policy?

13. Job title **(IMPORTANT: PLEASE ATTACH JOB DESCRIPTION)**

14. **Prior to disability, did you consider your employee able to perform (complete based upon employee's job prior to disability)?**
    - ❑ Sedentary Work: Lift 10lbs maximum and occasionally carry small objects
    - ❑ Light Work: Lift 20 lbs maximum and frequently lift/carry up to 10 lbs
    - ❑ Medium Work: Lift 50 lbs maximum and frequently lift/carry up to 25 lbs
    - ❑ Heavy Work: Lift 100 lbs maximum and frequently lift/carry up to 50 lbs
    - ❑ Very Heavy Work: Lift in excess of 100 lbs and frequently lift/carry 50 lbs

15. **Did the employee perform the following tasks (prior to disability)?**

	Never	Occasionally (1-33%)	Frequently (34-56%)	Continuously (57-100%)
Push/pull when seated	❑	❑	❑	❑
Push/pull when standing	❑	❑	❑	❑
Bend	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach above shoulder level	❑	❑	❑	❑

16. **Assuming an 8-hour workday with two fifteen-minute breaks and 1/2-hour meal break; I expect this employee to be able to:**

(circle the number of hours for each activity.)

Sit	1	2	3	4	5	6	7	8	Continuously	With Rest
Stand	1	2	3	4	5	6	7	8	Continuously	With Rest
Walk	1	2	3	4	5	6	7	8	Continuously	With Rest
Alternately sit / stand	1	2	3	4	5	6	7	8	Continuously	With Rest

Comments: ____

____

FICA TAX WITHHOLDING INFORMATION

17. Indicate employee's Social Security Identification Number as shown on your employment records:

18. Do you contribute 100% of the premium for the employee's short-term disability coverage? ❑ Yes ❑ No

If no, what percentage of the premium for such coverage is contributed by you ____________ %; by the employee ____________ %

19. Is the employee's percentage subject to a cafeteria plan? ❑ Yes ❑ No

20. Employer Name

21. Employer Address City State Zip

22. Employer Telephone Number

23. Employer Fax Number

24. Employer E-mail Address

25. Signature of Authorized Representative and Title

Date

MAIL OR FAX FORM TO: THE EPIC LIFE INSURANCE COMPANY
ATTN: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-223-2159

Short-Term Disability Claim Form

Attending Physician Statement

1. Patient's Name

2. Identification Number　　Date of birth

3. Date you first attended patient

4. Date you last attended patient

5. Date sickness or injury began

6. Diagnosis code (ICD-9 code)

7. Description

8. Medication(s) prescribed

9. If patient was hospitalized, please provide admit and discharge dates:

Admit ___________________________ Discharge ____________________________

10. Is this illness or injury work related? ❑ Yes ❑ No

11. Is this illness or injury intentionally self-inflicted or attempted suicide? ❑ Yes ❑ No
If yes, please provide details:

12. Is this illness or injury resulting from weight control or treatment of obesity not caused by an organic condition? ❑ Yes ❑ No
If yes, please describe your objective findings:

13. Has surgery been done? ❑ Yes ❑ No
If yes, date of surgery___________________________ What procedure was performed? ___________________________

14. To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment, advice or recommendations for this condition prior to this disability onset? ❑ Yes ❑ No
If Yes, please provide the name, address and telephone number of the referring physician.

15. **Physical restrictions/limitations (as defined in the 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%)

What are the patient's physical restrictions/limitations?

16. **Mental impairments (if applicable)**

❑ 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 or engage in 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 physiological, psychological, personal and social adjustment (severe limitations).

What are the patient's mental impairments?

For TOTAL DISABILITY, PARTIAL DISABILITY, or MATERNITY claims, please complete the appropriate section on the reverse side of this form.

TOTAL DISABILITY

17. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

18. What date did he/she become totally disabled (continuously unable to perform the functions of his/her occupation or to work for wage or profit)?

19. Has the patient been continuously totally disabled since this date? ❑ Yes ❑ No
    If no, what date was the patient no longer totally disabled?

20. What is the patient's expected return to work date?

21. Is the patient a candidate for partial disability? ❑ Yes ❑ No
    If yes, refer to PARTIAL DISABILITY section below.

PARTIAL DISABILITY

22. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

23. What date did he/she become partially disabled?

24. What is the number of days or hours the patient can resume part-time work?

25. What is the patient's expected return to work date on a full-time basis?

MATERNITY

26. Is this disability due to pregnancy? ❑ Yes ❑ No

27. If disability is prior to delivery, what are the complicating factors (be specific) and expected date of delivery?

28. What date did she become totally disabled (continuously unable to perform the functions of her occupation or to work for wage or profit)?

29. What was the patient's date of delivery?

30. Type of delivery? ❑ Vaginal ❑ C-section

31. What is the patient's expected return to work date?

Physician Information

Physician's Signature			Date
Physician Name (Please print)			
Physician Address	City	State	Zip
Physician Telephone Number			
Physician Fax Number			

MAIL OR FAX FORM TO: THE EPIC LIFE INSURANCE COMPANY
ATTN: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-223-2159