# FILING A SHORT TERM DISABILITY CLAIM:

The plan participant must be disabled as the result of a non-occupational injury or illness. Such disability must begin while the participant is covered under the employer's plan and has chosen the disability plan option. The disability must prevent the plan participant from performing any and every duty of their job.

## Completing the Claim Form:

The claim form has 3 sections that **MUST** be completed **IN FULL**. Please do not send in partially completed forms. This will cause delays in processing.

- Section 1 is completed by the member - please make sure your mailing address is correct
- Section 2 is completed by the employer
- Section 3 is completed by the attending physician and supporting medical records must be attached

*Please note: It is the member's responsibility to make sure that all necessary information and documentation to process the claim including but not limited to medical records, police reports, and/or accident details are submitted with claims.*

Once the claim form is completed, please submit via fax to 1-800-713-0294 or mail to:

Fringe Benefits Group
11910 Volente Road
Austin, Texas 78726

## Once your completed disability claim form and supporting documentation is received the following steps are taken:

1. The claims are received and scanned into our system
2. The claims are reviewed for completeness
3. Completed Claim Forms are forwarded to the Claims Processing Center
4. The initial determination is made
    a) Approved
    b) Denied
    c) Pending additional information
5. If approved there is a waiting period before the initial payment is sent out. This waiting period varies depending on your plan. Payments are sent out weekly by paper check so please make sure we have your correct mailing address.
6. If your doctor determines that you need to be out of work for a longer period of time than your benefits were approved you will need to submit a new Attending Physicians Statement (page 2 of the claim form) and supporting documentation (medical records).

If you require any assistance with completing your claim form or have any questions in regards to your disability benefits, please contact Member Services at 1-800-517-4791. Your Disability Representative's name is **Sheree** at **ext. 624**.

**Nationwide Life Insurance Company**
**Columbus, Ohio**

**DISABILITY CLAIM FORM** **GROUP INSURANCE**

INSTRUCTIONS: Immediately upon being furnished with this form, the Claimant should complete ALL questions in Section I and have the ATTENDING PHYSICIAN'S STATEMENT completed by his Doctor on back of form. The form should then be promptly sent to your Employer for completion of Section II as indicated. This form should be mailed to our Group Claims Office at the address on file with your Employer:

**SECTION I TO BE COMPLETED BY EMPLOYEE (PLEASE ANSWER ALL QUESTIONS)**

1. Policy and Certificate Number ______________________ Social Security Number ______________
2. Employee Name ______________________ Date of Birth ____/____/____
3. Employee's Address ______________________________________________
   Street City State ZIP
4. Employee Phone Number ______________________ Email Address (optional) ______________
5. Occupation ______________________ 6. Usual duties of your occupation ______________
7. Date accident occurred or sickness began ____/____/____ 8. Date you last worked ____/____/____
9 Nature of injury or sickness ______________________________________________
10. If injured, *how* and *where* did the accident occur? ______________________________________________
11. If sickness, when were first symptoms noticed? ______________________________________________
12. Have you missed any work for this injury or sickness before? ______________ If so, when? ______________
13. Physician's Name ______________________ Address ______________________
14. Date first treated ____/____/____ What surgery was performed? ______________________
15. Name and address of hospital ______________________________________________
   ______________________ 16. Confined from ____/____/____ To ____/____/____
16. On what date did you (or do you expect to) resume the usual duties of your occupation? ____/____/____
17. Do you want federal Income Tax withheld? ☐ Yes ☐ No (If "Yes," employer must submit W-4 form.)

By furnishing this blank the Company shall not be held to admit the validity of any claim or waive the breach of any condition of the policy.

I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish Nationwide Life Insurance Company of Columbus, Ohio, or its representative with full information regarding treatment rendered (including copies of records). I also authorize any Employer to furnish work attendance records and reason for my absences, or Insurance Carrier to furnish Nationwide Life Insurance Company of Columbus, Ohio, or its representative with medical information and/or information regarding benefits to which I may be entitled. A Photostatic copy hereof shall be as valid as the original.

Signed ______________________________________________ Date ____/____/____
(Employee Signature)

**SECTION II EMPLOYER OR ORGANIZATIONAL APPROVAL**

1. Date of Employment ______________________ Date last worked ______________________
2. Was employee actively employed at the time this claim was incurred? ☐ Yes ☐ No
   If "No" date employee ceased working 30 hours per week. ______________ Reason employee ceased work ______________
3. Effective date of employee's insurance ____/____/____ Date to which premium is paid for insured ____/____/____
4. First day insured disabled ____/____/____ Date returned to work or expected to return ____/____/____
5. Did condition arise from employment? ☐ Yes ☐ No If "Yes," explain ______________________
6. Is this a Section 125 Plan? ☐ Yes ☐ No 7. What percentage does the employer contribute towards the STD premium? ______%
8. Average weekly wages $ ______________

This is to certify that the above information is correct and the named employee or dependent is insured under the terms of the above numbered policy and that such insurance was in force on the date this claim was incurred.

______________________ ______________________ Date ____/____/____
(Name of Employer or Organization) (Name of Authorized Representative)

**YOUR ATTENDING PHYSICIAN MUST COMPLETE REVERSE SIDE**

## SECTION III ATTENDING PHYSICIAN'S STATEMENT

### 1. HISTORY

(a) When did symptoms first appear or accident happen? ______/______/______

(b) Date patient ceased work because of disability ______/______/______

(c) Has patient ever had similar condition? ☐ Yes ☐ No If "Yes," state when and describe ______________________________

______________________________________________________________________

(d) Names and addresses of other treating physicians

### 2. DIAGNOSIS (including any complication)

(a) Diagnosis: ______________________________________________

(b) Date of last examination ______/______/______

### 3. DATES OF TREATMENT

(a) Date of first visit ______/______/______

(b) Date of last visit ______/______/______

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify)

______________________________

### 4. PROGNOSIS

| | PATIENT'S JOB | | ANY OTHER WORK | |
|---|---|---|---|---|
| Is patient now totally disabled? | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| If "Yes," when will patient Recover sufficiently to perform duties ______/______/______ | ☐ 1 Mo. | ☐ 3-6 Mos. | ☐ 1 Mo. | ☐ 3-6 Mos. |
| | ☐ 1-3 Mos. | ☐ Never | ☐ 1-3 Mos. | ☐ Never |

If "No," please explain ______________________________________________

______________________________________________________________________

### 5. REMARKS

______________________________________________________________________

NAME (ATTENDING PHYSICIAN) PRINT DEGREE TELEPHONE

______________________________________________________________________

Street Address City State Zip

______________________________________________ Date ______/______/______

SIGNATURE

Return to: Nationwide Specialty Health
Attn: Disability Claims
11910 Volente Road
Austin, TX 78726
800-635-6585
800-713-0294 (fax)

**(California)** For your protection California law requires the following to appear on this form. For 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.

**(Florida)** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company 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 an application for insurance 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)** 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.

**(Missouri)** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

**(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 intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

**(Washington)** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

**(All Other States)** 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/or 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.