



WELLFLEET WORKPLACE

SHORT TERM DISABILITY POLICY & PREMIUM WAIVER CLAIM FORM

Submitting your claim

Submit your claim the way you like. Mail, email or fax your claim to:

Wellfleet Insurance Company
 P.O. Box 15769
 Springfield, MA 01115
 Fax: 413-452-5486
 Email: workplaceclaims@wellfleetinsurance.com

Helpful reminders

- Please complete all sections of this form.
- Make sure to sign and submit the "Authorization to Release Information to Wellfleet Form".
- The "Attending Physician's Statement" must be completed and signed by your attending physician.
- The "Employer's Statement" must be completed and signed by your employer.

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Care Team** at:

- workplaceclaims@wellfleetinsurance.com
- 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

CERTIFICATE HOLDER/CLAIMANT INFORMATION

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

Product(s) claiming Waiver of Premium: Accident Hospital Indemnity Critical Illness

Certificate number(s): _____

Certificate holder: First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Male Female

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Check here if address is new

Phone #: _____ E-mail: _____

Preferred communication with Wellfleet: Email Mail

Employer: _____ Occupation: _____

Job Responsibilities: (or attach job description) _____

Note: If premiums for this policy were paid with pre-tax dollars, FICA withholding will be deducted from claim payment.



DISABILITY CLAIM DETAILS

Please provide the following details regarding your condition and your ability to work.

What is your Diagnosis/Condition? _____

When did you first notice symptoms of your condition? _____

Is your condition due to an accidental injury? Yes No

Accident Date: _____ Time: _____ AM PM

How did your accidental injury happen? _____

Is your condition work related? Yes No

Has a Worker's Compensation claim been filed? Yes No

If yes, is the claim Approved Pending Denied

Was the claimant involved in a motor vehicle accident? Yes No If yes, Driver Passenger

Was a police report filed? Yes No If yes, please provide a copy of this report.

When was your first visit for this condition? _____ Most Recent Visit: _____

Next Visit: _____

Were you hospitalized for your condition? Yes No

Admission Date: _____ Discharge Date: _____

What was the first date you were unable to work? _____

Describe why you are unable to work: _____

What job duties are you unable to perform? _____

Have you returned to work? Yes No

Part-time/Partial duties: ____/____/____ Full-time/Full duties: ____/____/____

Is your condition Pregnancy? Yes No Due Date: _____ Delivery Date: _____

Normal Delivery C-Section Were there complications of pregnancy? Yes No

If yes, please explain _____

Prior Disability coverage

We may require proof of prior disability coverage for review.

Did you have prior disability income coverage that was canceled and replaced with this policy? Yes No

Provide details: _____

Prior Disability Insurance Company Name: _____

Effective date of other coverage: _____ Termination date of other coverage: _____

Other Disability income

Please provide a copy of the approval or denial notification from other source.

Do you have other Disability Income Coverage? Yes No If yes, please see below.

Type of coverage: Worker's Compensation Employer's Liability Other _____

Disability Insurance Company Name: _____

Effective date of other coverage: _____ Claim begin date: _____ Claim end date: _____



Providers

Please list all providers you have seen in the past 2 years, including the providers treating you for this condition. If more space is needed, complete the necessary information on a separate piece of paper.

1. _____
Attending Physician's Name Address Phone #

Specialty Dates Consulted Reasons for Visit/Condition

2. _____
Attending Physician's Name Address Phone #

Specialty Dates Consulted Reasons for Visit/Condition

3. _____
Attending Physician's Name Address Phone #

Specialty Dates Consulted Reasons for Visit/Condition

4. _____
Attending Physician's Name Address Phone #

Specialty Dates Consulted Reasons for Visit/Condition

Optional riders purchased by your employer

Check the boxes next to the riders that apply, then provide the requested information/documentation.

- Medical Insurance Premium Benefit Rider:** Provide documentation of medical premiums.
- Caregiver Leave of Absence Benefit Rider:** Provide documentation that you have an approved leave to care for a spouse, child or parent who has a serious health condition as defined by FMLA.
- Building Benefits Rider:** Provide initial effective date of coverage.
- Non-Disabling Injury Benefit Rider:** Provide proof of injury. Employer Statement not required.

CERTIFICATION

Please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and am aware that it is a crime to fill out this form with facts I know are false or leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete and correctly recorded.

Please also remember to sign and date the attached authorization required to process your claim.

Signature: _____ Print Name: _____ Date: _____



ATTENDING PHYSICIAN'S STATEMENT

To be completed and signed by the attending physician.

SECTION #1: Describe the Condition

ICD 9/10 Code: _____ Primary Diagnosis: _____

ICD 9/10 Code: _____ Secondary Diagnosis: _____

Other Condition(s): _____

When did symptoms first appear? _____

If applicable, what is the accident date? _____

Has the patient ever had the same / similar condition? Yes No When: _____

Is the condition due to injury or sickness arising out of the patient's employment? Yes No

Pregnancy or Complication of Pregnancy: Due Date: _____ Delivery Date: _____

Normal Delivery C-Section

SECTION #2: Treatment Required

First Consultation: _____ Most recent consultation: _____

Next consultation: _____ Released: _____

Is a Surgical or Medical Procedure required? Yes No Date: _____

Procedure Code: _____ Procedure: _____

Is Hospitalization required? Yes No Admission date: _____ Discharge date: _____

Hospital: _____ City: _____ State: _____

What is the current treatment plan? _____

SECTION #3: Restrictions, Limitations & Ability to Work

The patient **IS ABLE** to work in the following capacity:

No Work Sedentary Light Medium Heavy Very Heavy

The patient **IS UNABLE** to perform their job duties: Yes No If yes: From _____ Through _____

When is the patient expected to **RESUME WORK**?

Part-time Duties: _____ Full-time Duties: _____

Please provide specific **RESTRICTIONS** (what the patient shouldn't do)?

Please provide specific **LIMITATIONS** (what the patient cannot do)?

What clinical or diagnostic findings support the above?

SECTION #4 Referring Physician

Name: _____ Specialty: _____

Address: _____ Phone #: _____

SECTION #5 Attending Physician Verification

Signed: _____ Date: _____ Phone#: _____

Street Address: _____

City/Town: _____ State: _____ Zip Code: _____



EMPLOYER'S STATEMENT

To be completed and signed by your employer. If you are unemployed, please provide the last day you worked, your prior employer's name and sign this form.

SECTION #1: Employment Information/Job Description

Check here if: Self-employed or Unemployed

Name of Employer/Company: _____

Date of Hire: _____ Employee's Job Title: _____

Please attach copy of job description and responsibilities.

This job is classified as: Sedentary Light Medium Heavy Very Heavy

Prior to inability to work, he/she worked _____ hours per week.

Hourly pay \$ _____ Annual salary \$ _____

SECTION #2: Dates Missed Work/Return to Work

What dates was the employee unable to perform any part of their work:

From _____ through _____

Has the employee returned to work? Yes No

Part-time/Partial duties date: _____ Full-time date: _____

Did the employee work part-time/partial duty? Yes No Dates: _____

Is part-time/partial duty work available? Yes No Reason: _____

SECTION #3: Workers' Compensation / Other Disability Coverage

Is this a work-related condition/injury? Yes No

Workers' Compensation begin date: _____ End date: _____

Workers' Compensation Carrier: _____ Benefit amount: \$ _____ Monthly/ Weekly

Is employee covered under any other Disability Policy? Yes No

Other Disability Insurance Carrier: _____ Benefit amount: \$ _____ Monthly/Weekly

SECTION #4: Premium

Pre-Tax Premium: Were the premiums for this disability income paid with Pre-Tax Dollars? Yes No

Note: If yes, FICA withholding will be deducted from the disability claim payment.

Employer-Paid: Were premiums for this disability income employer-paid? Yes No

SECTION #5: Employer Verification

Signed by: _____ Print Name: _____ Date: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

Email address: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information

Complete the necessary information for the claimant whose information will be released.

Name: _____
(Last, First, Middle)

Date of Birth: ____/____/____

Other Name Used: _____

Social Security Number: ____ - ____ - _____

Signature of Claimant: _____

Date signed: ____/____/____

I authorize any: licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer; to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Authorized Representative Information

Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless a parent is signing for patient under 18.

Name: _____
(Last, First, Middle)

Mailing Address: _____

Relationship to Claimant: _____

Phone: ____ - ____ - _____

Description of the information to be disclosed

I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV-related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration

Unless revoked as discussed below, this Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed or for the duration of the claim for benefits, whichever the shorter.



Right to Revoke

I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights

1. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.



FRAUD NOTICES

For residents of all states, other than those listed below. Any person who knowingly 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.

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

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California. For your protection California law requires the following to appear on this form: 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.

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.

Delaware Idaho, Indiana & Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: 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 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.

Maine: 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 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.

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 files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly 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 civil fines and criminal 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.



Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should 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.

Tennessee, Virginia & Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.