



# 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](mailto: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](mailto: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 statement to appear on this form. Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or make 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.