BlueCross BlueShield of Illinois

Group Short-Term Disability Claim Form

Phone Number: (800) 367-6401
Fax: (877) 404-6457

Return to Blue Cross and Blue Shield of Illinois at:
Attention: Claim Department
PO Box 7071
Downers Grove, IL 60515

A complete submission consists of the **REQUIRED** items listed below

- You may submit each section separately or together.
- Please print all information requested.
- If a date is requested, enter month, day and year.
- Be certain to sign and date all forms.
- When at least one of the Required sections is received, we will mail you an acknowledgement letter that will provide you with your claim number.
- Once all Required sections are received, we will begin our evaluation of your claim.

REQUIRED - THE FOLLOWING FORMS MUST BE SUBMITTED FOR US TO EVALUATE YOUR CLAIM

1. **Employee Statement** - To be completed by the employee who is applying for Short-Term Disability benefits

2. **Authorization for Release of Medical and Other Information** - To be completed by the employee. Print your name, sign and date this form. Provide a copy to your attending physician(s).

3. **Employer Statement** - Ask your employer to complete, sign and date the form. Your employer should attach: (1) Job Description, (2) Proof of enrollment if you elected this coverage, (3) Documentation of earnings if your benefit is based on something other than straight salary (e.g., prior year W-2, monthly commissions), (4) if Workers' Compensation claim filed, include copy of First Report and decision.

4. **Attending Physician Statement -** Ask your physician to complete the form by printing the information regarding your condition, then signing and dating the form.

OPTIONAL - IT IS YOUR CHOICE TO SUBMIT EITHER (OR BOTH) OF THE FOLLOWING FORMS

1. **Direct Deposit Authorization Form** - If your claim is approved, you can choose to receive your payments via direct deposit to a savings or checking account. If you wish to have direct deposit please complete the Direct Deposit Form and send to us at the address shown above. If you do not elect direct deposit, your benefit checks will be mailed.

2. **Authorization to Disclose Information to Third Parties** - If you authorize us to discuss your claim with a third party (e.g., Family member, friend, legal representative) complete this form and return it to us.

ONCE EACH SECTION ABOVE IS COMPLETED, SIGNED AND DATED, IT CAN BE SENT VIA FAX TO (877) 404-6457, OR MAILED TO THE ADDRESS ABOVE. EACH SECTION MAY BE SUBMITTED SEPARATELY.

We will do our best to expedite your claim decision.

If you have questions, please contact us at (800) 367-6401 from 8:00 AM to 8:00 PM EST, Monday through Friday.

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EMPLOYEE STATEMENT (Please Print)

Employee Name (Last)	(First)	(MI)	Social Security #	Birthdate

Address	City	State	Zip	Phone #

Maiden Name	Alias Name	E-mail

Name of Employer	Occupation	Location

Have you or do you plan to file a Workers' Compensation claim for this Disability: ☐ Yes ☐ No

Have you or do you plan to file for Social Security benefits for this Disability: ☐ Yes ☐ No

Describe other income you are receiving:

YES	NO	TYPE *	AMOUNT	DATE BENEFITS BEGAN	DATE BENEFITS TERMINATED	NAME OF INSURANCE CARRIER
☐	☐	Social Security (disability or retirement)	$			
☐	☐	State disability	$			
☐	☐	Retirement (normal, early or disability)	$			
☐	☐	Workers' Compensation	$			
☐	☐	Group disability benefits	$			
☐	☐	Other (describe)	$			

* *Please send a copy of your award letter, if applicable.*

Is Your Disability caused by: ☐ Sickness ☐ Accident ☐ Maternity

If Maternity Claim

1. Date of Delivery: _____ ☐ Estimated ☐ Actual 2. Type of Delivery: ☐ Vaginal ☐ C-Section ☐ Unknown at this time

3. Were there any complications causing you to stop work prior to your expected delivery date: If yes, please explain: _____

If Sickness / Accident Claim

1. Date of accident or beginning of sickness: _____ Date last worked ("DLW"): _____ # Hrs worked on DLW: _____

2. If Sickness, provide details: _____

2a. Have you ever had same or similar sickness: ☐ Yes ☐ No If yes, give dates: From _____ To _____

3. If Accident, ☐ Motor Vehicle Accident ("MVA") ☐ Other Provide details: _____

3a. If MVA, was an accident report filed: ☐ Yes ☐ No If yes, provide copy of accident report with your claim.

4. Provide date you were unable to perform your occupation due to your medical condition: From _____ To _____

All Claims (If you have multiple providers, please provide their information on a separate sheet of paper.)

1. Name and address of Doctor(s): _____ Dr. Ph. # _____ Dr. Fax # _____

Dates of treatment: _____

2. Name of hospital(s): _____ Dates confined: From _____ To _____

Address of hospital(s): _____

Hospital Ph. # _____ Hospital Fax # _____

3. I returned to work Full-time on: _____ Part-time on: _____

4. FICA Tax - If your request for benefits is approved, FICA tax will be withheld as required per IRS.

FIT - Do you wish us to withhold Federal Income Tax from your benefits: ☐ Yes ☐ No

If yes, how much should be withheld each week: (minimum is $20.00 per week) _____

Signature of Employee _____ Date _____

BlueCross BlueShield of Illinois

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION

To Be Completed by Employee:

TO:

- Physicians and Other Health Care Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Pharmacies and Pharmacy Benefit Managers
- State Vocational Rehabilitation Agencies and other providers of rehabilitation services
- Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors
  Insurers, including workers' compensation insurers or administrators, and Pre-Paid Health Plans
- Medical Information Bureau (MIB) or other companies, which collect health and insurance information
- Hospitals, Clinics and Health Care Facilities
- Governmental Agencies (including and not limited to the Social Security Administration ("SSA"), Internal Revenue Service, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Employers
- Attorney Representatives
- Advocates for SSA or Benefits Programs

You are authorized to provide information related to my health condition and job modifications/accommodations with my current or future employer to:

- Blue Cross and Blue Shield of Illinois;
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

This form allows the release of the following information, collectively referred to as "Information":

- Records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations and prescriptions;
- Employment-related information, including any claims for workers' compensation;
- Income and tax-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering benefits for short-term disability, long-term disability, salary continuation, workers' compensation, which are excepted benefits under HIPAA, or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), developing a vocational rehabilitation plan, and other purposes in connection with the administration of the Benefits Program,.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program under which I may be a participant, employers, reinsurers, the SSA, claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain valid during the duration of my claim or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address below. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of BCBSIL to process my claim and may lead to the denying or terminating of my claim for benefits.

Employee's Signature _____ Date _____

Employee's Full Name _____ Date of Birth _____

If the Employee is unable to sign, an authorized representative may sign below for the Employee

Representative's Signature _____ Date _____

Representative's relationship to Employee: _____ Phone # _____

PO Box 7071, Downers Grove, IL 60515 . Toll Free: 800.367.6401 . Fax: 877.404.6457

BlueCross BlueShield of Illinois

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Phone Number: (800) 367-6401
Fax: (877) 404-6457

Mail form to:
Blue Cross and Blue Shield of Illinois
PO Box 7071
Downers Grove, IL 60515

☐ New Direct Deposit ☐ Cancel Direct Deposit ☐ Change to Current Direct Deposit

Please Print

Name:	Social Security Number:	Claim Number if known:

Fill out either the Checking Account Information Section or the Savings Account/Credit Union Information Section.
You may indicate **one account only.**

Checking Account Information

Obtain this information directly from the bottom of your check or from your financial institution.

Name of Financial Institution:	
Address of Financial Institution:	
Routing Number (first number on bottom left of check):	Account Number (second number on bottom of check):

Savings Account/Credit Union Information

Obtain this information from your financial institution.
The information on your deposit slip is **not** applicable for this purpose.

Name of Financial Institution:	
Address of Financial Institution:	
Routing Number (first number on bottom left of check):	Account Number (second number on bottom of check):

Authorization

I hereby authorize the company to initiate credit entries and if necessary, debit entries and adjustments for any credit entries made in error to my account, with the financial institution indicated. The financial institution is authorized by me to credit or debit my account for the amount of those entries.

This authorization is to remain in effect until the company has received written notification from me of its termination in such time and in such manner as to afford the company a reasonable opportunity to act on it.

Signature:	Date:

BlueCross BlueShield of Illinois

Third Party Authorization

Return to Blue Cross and Blue Shield of Illinois at:
Attention: Claim Department
PO Box 7071
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax: (877) 404-6457

Complete this form if you wish for Blue Cross and Blue Shield of Illinois employees or duly authorized representatives to communicate with a family member, friend or other third party about your claim. You must read this form carefully, complete it in its entirety, sign and date it, and fax or mail it to the fax number or address above.

To assist in the evaluation or administration of my claim(s), I authorize BCBSIL to provide and receive health and financial information relating to my claim from/with the family member(s), friend(s), and/or other third parties listed below:

☐ My Spouse:
Name (Last) (First) (MI) Phone Number

☐ Family Member:
Name (Last) (First) (MI) Relationship Phone Number

☐ Other Third Party:
Name (Last) (First) (MI) Relationship Phone Number

☐ I authorize BCBSIL to leave messages about my claim on my voicemail/answering machine.

Unless otherwise revoked, this Optional Authorization is to remain in effect for a period of:

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months* from the signature date below

*A new Optional Authorization must be completed and submitted at the end of each 12 month period. For periods greater than 12 months, you may want to consult an attorney to determine whether a Power of Attorney (POA) would be a more appropriate option.

In executing this Authorization:

- I understand that information about my claim may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment but does not include psychotherapy notes.
- I understand that the information provided to the designated individual(s) is subject to redisclosure and might not be protected by certain state and federal regulations governing the privacy of health and financial information.
- I understand that this authorization is valid only for the period chosen above.
- I understand that the terms of the authorization will remain in force with any claim that transitions with BCBSIL from Short-Term Disability to Long-Term Disability and/or Long-Term Disability to Life Waiver of Premium and/or Life Waiver of Premium to Life and/or Life to Critical Illness.
- I understand that I may revoke this Optional Authorization at any time and that such revocation will take effect only upon receipt of written notice by BCBSIL at the address listed above.
- I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial Authorization.

I may request a copy of this authorization and a copy shall be as valid as the original.

Printed Name (Last) (First) (MI) Claim Number

Claimant Signature Date

If completed by Power of Attorney Designee, Personal Representative, Guardian, or Conservator, please sign below and **attach a copy of the document granting authority**.

Printed Name (Last) (First) (MI) Relationship

Signature Date

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EMPLOYER STATEMENT (Please Print)

Employer Name				Group #
Employer Address	City	State	Zip	Phone #
Division/Location	Subsidiary Name	Contact Person		
Contact Person Phone #	Contact Person E-mail	Contact Person Fax #		
Employee Name (Last)	(First)	(MI)	Social Security #	Employee ID #
Employee Occupation / Job Title (Attach Job Description)	Job Class ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy			
Effective Date of STD Coverage	Did Employee have Coverage under Prior STD Policy: ☐ Yes ☐ No	STD Coverage Effective Date Under Prior STD Policy		

Other Coverages Employee has through BCBSIL:

☐ Long-Term Disability ☐ Life ☐ Critical Illness ☐ Accident ☐ Accidental Death & Dismemberment

Date of Hire	Last Day Worked ☐ FT ☐ PT	First Date of Absence	Date Returned to Work ☐ FT ☐ PT	Termination Date (if applicable)
Class #	Hours Worked Per Week ☐ FT ☐ PT	Salary ☐ Hourly ☐ Biweekly ☐ Semimonthly ☐ Prior Year W2* ☐ Weekly ☐ Monthly ☐ Annual		

*If policy defines Salary as Prior Year W2, include copy of last year's W2 with claim form.

Amount of weekly disability benefit $ _____ (SELF-ADMINISTERED ONLY)

Employee received (date):
Salary continuation through _____
Vacation through _____
Sick Leave through _____
PTO through _____

Workers' Compensation (W/C) Claim Filed for this Disability: ☐ Yes ☐ No

If yes, provide W/C Carrier Name: _____

W/C Contact Person's Name and Phone: _____

If the Employee is released to return to work in restricted duty, are you willing to discuss accommodations: ☐ Yes ☐ No

If yes, provide contact name and phone #: _____

Premium Contributions - if this section is not completed, the claim will be taxed at 100%

Do you gross up Employee's salary to cover premiums: ☐ Yes ☐ No

Does the Employee contribute toward the cost of this STD insurance: ☐ Yes ☐ No If "Yes": ☐ Pre-Tax ☐ Post-Tax

Employee pays _____ % of premium, Employer pays _____ % of premium.

See IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for more information on calculating the taxable percentage.

Signature of Authorized Employer/Plan Representative	Date Signed
Print Name	
Telephone # / Fax # / E-mail Address	

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ATTENDING PHYSICIAN STATEMENT (Please Print)

(Must be completed in full at the patient's expense)

Employee's Name (Last)	(First)	(MI)	☐ Male ☐ Female	Birthdate	Age
Address	City	State / Zip		Height	Weight

Is the Disability caused by: ☐ Sickness ☐ Accident ☐ Maternity

Maternity Claim

1. Date of Delivery: _____ ☐ Estimated ☐ Actual 2. Type of Delivery: ☐ Vaginal ☐ C-Section 3. Date of LMP: _____

4. Were there any complications causing the patient to stop work prior to your expected delivery date: If yes, please explain:

All Other Claims / Diagnosis

1. Primary ICD10 Diagnosis Code: _____ Diagnosis: _____
2. Secondary ICD10 Diagnosis Code: _____ Diagnosis: _____
3. Date symptoms first appeared or date of accident: _____ Date patient first consulted you for this condition: _____
4. Is the condition work related: ☐ Yes ☐ No _____
5. Describe any other disease or complications affecting present condition: _____

All Other Claims / Treatment

1. Surgery Date: _____ CPT Code: _____ Details: _____
2. Dates of treatment other than surgical: _____
3. Hospital name & address with dates of confinement: From _____ To _____ ☐ Inpatient ☐ Outpatient
   Hospital name: _____ Hospital address: _____ Hospital Ph. # _____
4. Has patient ever had same or similar condition: ☐ Yes ☐ No (If yes, state when and describe)

5a. Is patient still under your care: ☐ Yes ☐ No 5b. Date of next office visit: _____ 5c. Frequency of visits: _____

6. Is patient under the care of another physician: ☐ Yes ☐ No (If yes, provide name, address and phone # of physician)

All Other Claims / Impairment

1. Patient was or will be continuously unable to work:
   In his/her own occupation: From _____ To _____ In his/her own occupation: From _____ To _____
   Patient can return to work: ☐ Full time ☐ Part time On _____

   Current Limitations - What the *patient cannot do*: _____

   Current Restrictions - What the *patient should not do*: _____

2. How long do you expect these restrictions and limitations to impair your patient:
   ☐ Date _____ ☐ Unable to determine, follow up in _____ weeks ☐ Permanently
3. In your opinion, is patient candidate for rehabilitation: ☐ Yes ☐ No
4. If patient is diagnosed as terminal, is life expectancy: ☐ 6 months or less ☐ 12 months or less ☐ Other _____

Remarks _____

Physician Name _____ Phone # _____ Fax # _____

Physician Signature _____ Date _____

Address _____ City _____ State _____ Zip _____

Specialty: ☐ FP ☐ IM ☐ PM&R ☐ Neuro ☐ Ortho ☐ OBG ☐ Psych ☐ Other _____

Tax ID # _____ NPI # _____

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BlueCross BlueShield of Illinois

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

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.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Ohio: Any person who, with intent to defraud or knowingly 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.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

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 be 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.

Rhode Island: 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.

Tennessee: 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.

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.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

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.

Arkansas: 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.

Delaware: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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 NH 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.

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.

FOR APPLICATIONS ONLY:

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.