Great-West®
HEALTHCARE
888-565-5910

Short Term Disability Claim Form

All Claims Must Be Authorized and Submitted Through Employer

HOW TO FILE A CLAIM

MEMBER	PHYSICIAN
1. Complete Part A. 2. Have Attending Physician Complete Part C 3. Have Your Employer Complete Part B.	1. Complete Part C. 2. Return Complete Form to Patient.

EMPLOYER
1. Complete Part B.
2. Forward Completed Form to P.O. Box 1080, Denver, CO 80201.
3. ADVISE WHEN MEMBER RETURNS TO WORK.

PART A MEMBER STATEMENT

Failure to Answer All Questions May Delay Payment

1. Member's Name | Street Address | City | ST | ZIP | Telephone Number ( )

2. Plan Number **(Must Be Completed)** | Social Security No. **(Must Be Completed)** | Are you still employed? ☐ Yes ☐ No | If no, date last worked / /

3. Date of Birth / / | Gender ☐ M ☐ F | Name of Your Employer | Occupation

4. Is claim for an accident? ☐ Yes ☐ No | Date: / / | Time: AM PM | Where did it occur? | While working? ☐ Yes ☐ No | How did it occur?

5. List names and addresses of all physicians treating you for this disability. | Dates of Service

	/ /
	/ /
	/ /
	/ /
	/ /
	/ /

6. Describe how your illness or injury prevents or has prevented you from working. Please use additional sheet if necessary.

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 such violation.
SIGN HERE. I hereby authorize any insurance company, hospital or physician to release all information which may have a bearing on benefits payable under this plan of benefits to Great-West Healthcare or its authorized representative who is employed to assist in the evaluation of my claim.

7. | **Date:** / /

PART B ADMINISTRATOR'S STATEMENT

1. Plan No. | Division Number/Class (if applicable) | Plan Name/Division Name

2. Date of Hire / / | Effective Date of Coverage / / | Date of Termination / /

3. Date Member Last Worked / / | Date Member Returned to Work / / | Occupation | Weekly Wage | Is patient entitled to workmen's compensation for this claim? ☐ Yes ☐ No

4. Does member work part-time ☐ or full-time ☐ ? | Number of hours worked on a weekly basis:

I HEREBY RECOMMEND THIS CLAIM RECEIVE CONSIDERATION
Authorized Signature
5. | **Date:** / /

Telephone Number ( ) | Fax Number ( ) | Date Salary Continuance / sick pay / vacation pay ended:

NOTICE: Filing a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states. See the attached Additional Disclosure Information for your state of residence.

Authorization is valid for the duration of the claim. Claimant or Claimant's authorized representative is entitled to receive a copy of this form.

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to New England Life Insurance Company's and Metropolitan Life Insurance Company's group business currently administered by Great-West. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.

PART C ATTENDING PHYSICIAN'S STATEMENT

Dear Doctor: The purpose of this report is to assist us in making a determination of disability. In filling out this report include sufficient details of physical and diagnostic findings, clinical course, therapy and response to treatment to enable us to make this determination.

Name of Patient	Date of Birth / /

1. HISTORY

(a) When did symptoms first appear or accident happen? Mo.______ Day______ Yr.______

(b) Date patient ceased work due to condition. Mo.______ Day______ Yr.______

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" state when and describe.

____

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

2. DIAGNOSIS (please include ICD #)

(a) Diagnosis (including any complications) If Pregnancy, attach Prenatal records. ________________

(b) Subjective symptoms ________________

(c) Objective findings (including results of current X-rays, EKGs, Laboratory Data and any clinical findings) ________________

3. DATES OF TREATMENT

(a) Date of first visit____/____/____ (b) Date of last visit____/____/____

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) ________________

4. NATURE OF TREATMENT (Please detail and include any surgery and medications prescribed)

5. PROGRESS

(a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Has patient been hospital confined? ☐ Yes ☐ No If yes, date: / / through / /

Name and Address of Hospital:

6. PROGNOSIS

	Patient's Job		Any Other Work	
(a) Is patient able to perform current occupation?	☐ Yes	☐ No	☐ Yes	☐ No
(b) Do you expect a fundamental or marked change in the future?	☐ Yes	☐ No	☐ Yes	☐ No

(c) When will patient recover sufficiently to perform duties? Full Time ______ Part Time ______

(d) What specific medical restrictions prevent the patient from performing his/her occupation?

7. PREGNANCY CLAIMS

Delivery date __________ or EDC __________

Note: **Pre-partum records required for any period of disability requested, prior to delivery.**

Name of Attending Physician (Print)	Degree	Telephone Number ( )		Fax Number ( )
Street Address	City		ST	ZIP

***** NOTICE: SEE FRAUD WARNING STATEMENT ABOVE.***** Signature of Physician (signature stamp will not be accepted)	Date / /

Additional Disclosure Information

This Disclosure Information forms a part of the Application for Membership as fully as if it were contained over the applicant's signature.

Alaska residents - 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 residents - 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 residents - 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.

California residents - 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 residents - 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 residents - 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 residents - 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 residents - Any person who knowingly, and with intent to injure, defraud, or deceives any insurer files a statement of claim or an application containing any false, incomplete, misleading information is guilty of a felony of the third degree.

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

Indiana residents - 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.

Kentucky residents - 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.

Louisiana residents - 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 maybe subject to fines and confinement in prison.

Maine residents - 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.

Minnesota residents - 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 residents - 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 residents - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico residents - 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 and criminal penalties.

New York residents Fraud Warnings for AD&A only - Any person who knowingly and with intent to defraud any insurance company or other person files and 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 residents - 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.

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

Oregon residents - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania residents - 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.

Tennessee residents - 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 residents - 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.

Virginia residents - 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.

Residence of all other states - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.