

PLEASE COMPLETE IN FULL AND RETURN WITHIN 30 DAYS.



The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
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Disability Income Plan Claim Application PLEASE PRINT

FOR OFFICE USE ONLY: DIP ADHIP HIP EMERGICARE SIP MAC

CLAIMANT INFORMATION

Policy Number: _____

- 1. Name: _____ Phone: (_____) _____
First, MI, Last
- 2. Address: _____
Street City State/Prov. Postal Code
- 3. New Address? Yes No Temporary Address? Yes No If "Yes," for how long? _____
Email Address: _____
- 4. Date of Birth: ____/____/____ 5. Sex: Male Female 6. Height: _____ 7. Weight: _____
Month/Day/Year
- 8. Occupation: _____ Retired?: Yes No
- 9. Employer's Name: _____ Phone: (_____) _____
- 10. Employer's Address: _____
Street City State/Prov. Postal Code
- 11. Position Held: _____ Description of Duties: _____
- 12. Type of Business (manufacturing, construction, retail, etc.) _____

ACCIDENT INFORMATION

- 13. Date of Accident: ____/____/____ 14. Time of Accident: ____:____ am/pm 15. Date Physician First Contacted: ____/____/____
Month/Day/Year Month/Day/Year
- 16. Describe Injuries: _____
- 17. Describe Accident: _____
- 18. If accident occurred on job, check here:

DISABILITY

- 19. If you are NOT claiming disability, please check here: and attach copies of itemized bills.
If you ARE claiming disability, please continue.
- 20. **TOTAL** Disability: From ____/____/____ am/pm To ____/____/____ am/pm
Month/Day/Year Month/Day/Year
PARTIAL Disability: From ____/____/____ am/pm To ____/____/____ am/pm
Month/Day/Year Month/Day/Year
- 21. Is disability continuing? Yes No
- 22. What duties are you unable to accomplish? _____

HOSPITALIZATION (PLEASE ATTACH COPIES OF SUMMARY SHEETS FROM ANY AND ALL CONFINEMENTS)

- 23. Were you confined to a hospital? Yes No If "Yes," please indicate the following:
- 24. Name of Hospital: _____
- 25. Address: _____
Street City State/Prov. Postal Code
- 26. Dates of Confinement: From ____/____/____ am/pm To ____/____/____ am/pm
Month/Day/Year Month/Day/Year

COMMENTS: _____

In Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
In Other States: 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.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to my physical or mental condition and/or treatment and any other non-medical information, to give The Order of United Commercial Travelers of America or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I am not required to sign this authorization form and that UCT will not condition the provision of payment for benefits to me on the signing of this authorization. However, UCT may condition payment of a claim for benefits on my authorization for disclosure of my information held by another person or entity, if such information is necessary to determine payment of a claim.

I agree that this authorization shall be valid for one year from the date shown below.

Release of all treatment records from: _____ to: _____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the *Notice of Privacy Practices* of UCT. I understand that I may revoke this authorization in writing at anytime, except to the extent that action has already been taken by UCT in reliance on this authorization, by sending a written revocation to UCT, Privacy Officer, 1801 Watermark Drive, Suite 100, Columbus, OH 43215.

Name of Insured: _____ Social Security No.: _____ Date of Birth: _____

Date: ____/____/____ Signature: **X** _____
Month/Day/Year (Signature of Claimant or Representative)

**If signed by a guardian or a power of attorney, we must have notarized papers verifying this.
ANY COST FOR COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT**

ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY YOUR DOCTOR)

1. Patient's Name: _____ 2. Date of Birth: ____/____/____
Month/Day/Year

3. Diagnosis: _____

4. Accident?: Yes No If "Yes," date of accident: ____/____/____ First date seen: ____/____/____
Month/Day/Year Month/Day/Year

5. Description of Accident: _____

6. Please list all treatment dates: _____

7. Was the patient hospitalized? Yes No If "Yes," when? From ____/____/____ am/pm To ____/____/____ am/pm
Month/Day/Year Month/Day/Year

8. Dates of Disability: **TOTAL** Disability: From ____/____/____ am/pm To ____/____/____ am/pm
Month/Day/Year Month/Day/Year

PARTIAL Disability: From ____/____/____ am/pm To ____/____/____ am/pm
Month/Day/Year Month/Day/Year

9. Is disability continuing? Yes No If "Yes," please estimate recovery time: ____/____/____
Month/Day/Year

10. Please list referring physician and their address: _____

11. Has claimant ever received treatment for the same or similar condition? Yes No If "Yes," please elaborate: _____

12. Charge for office calls: \$ _____ Charge for X-rays: \$ _____

13. Physician's Name: _____ 14. Physician's Phone: _____

15. Physician's Address: _____
Street City State/Prov. Postal Code

16. Physician's Signature: **X**: _____ Degree: _____ Date: ____/____/____
Month/Day/Year

COMMENTS: _____