



PO Box 1650
Little Rock, AR 72203-1650

Short Term Disability Instructions for Filing Claims

Dear Insured:

US Able Life is pleased to provide you coverage when you are unable to work due to a covered disability. We have included these instructions and the necessary forms to assist you in the event you need to file a claim for short term disability benefits. Please remember that all forms must be received within 90 days of the date you stop work.

Employee Statement

1. Complete the Employee Statement in full.
2. Answer all questions or state "not applicable".
3. Review the attached Fraud Statement as it applies to your state of residence, sign and date.
4. Sign and date the Authorization form.

Employer & Attending Physician Statements

1. Obtain the statement of your Attending Physician who will certify your disability.
2. Obtain the statement of your Employer.

Return All Forms to US Able Life:

Email: claims@usablelife.com

Facsimile: (501) 235-8417

Mail: PO Box 1650, Little Rock, AR 72203-1650

For Questions or Assistance Call or Contact US Able Life:

Telephone: (800) 370-5856

Email: claims@usablelife.com



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856 Fax (501) 235-8417
E-mail: claims@usablelife.com

Statement of Claim Short Term Disability Income Benefits Employee's Statement

For H.O. Use Only	
Eff	_____
PTD	_____
Benefits	_____

Instructions

1. Please type or print in blue or black ink.
2. Please make sure all questions on Employee's Statement are completed in full.
3. Employer's and Physician's Statements must be completed.
4. Authorization and Fraud Notice must be signed and currently dated.
5. Email, fax or mail the completed form to US Able Life.

EMPLOYEE'S STATEMENT			
Full Name (First, Middle, Last)		Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		Date of Birth	Occupation
City, State, Zip		Telephone Numbers Home _____ Work _____	
Claim is for <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy		Nature of Accident or Sickness	
Date of 1st Treatment	Physician or Hospital First Treated By		First Full Day of Disability
If accident, how did the accident occur? _____			
Accident Date _____ Time _____ <input type="checkbox"/> A. M. <input type="checkbox"/> P. M. Place _____			
Was a third party responsible for accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, third party's name _____			
Third party's address _____			
Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability			
Your Social Security: (disability or retirement) <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo. V.A. Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo.			
Dependent Social Security: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo. Worker's Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Wk.			
Sick Leave or Wage Continuation: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Wk. Other Disability Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Wk.			
Retirement: (normal, early or disability) <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo. (identify) _____			
State Disability Income: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Wk. Include a copy of your award or denial letter for any			
Unemployment: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Wk. source in which one has been received.			
Names and addresses of all doctors consulted for this condition (Use separate sheet if necessary):			
Physician	Date Treated/Consulted	Address, City, State and Zip Code	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Have you ever had this or similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give particulars: Date _____			
Describe _____			
Names and addresses of all doctors seen for any condition in the past five years (Use separate sheet if necessary):			
Physician	Date Treated/Consulted	Address, City, State and Zip Code	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



P.O. Box 1650 – Little Rock, Arkansas 72203-1650

FRAUD NOTICE

AZ Residents Only: Upon written request, we will provide you with information regarding the benefits and provisions of the annuity contract for which you are applying. If you are not satisfied with this contract, you may return it within 10 days, or 30 days if the owner is age 65 or over, after the date you receive it. Any premium paid will be refunded without interest.

AR, LA, NM, and OK Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime in certain states, a felony. Penalties may include imprisonment.

CA Residents Only: § 789.8 The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties. You or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

District of Columbia Residents Only: 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.

FL Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

MD Residents Only: "Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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."

ME and TN Residents Only: 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.

OH Residents Only: Any person who, with the 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.

Rhode Island Residents Only: 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."

VA Residents Only: 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.

WA Residents Only: 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.

Date

Signature



P.O. Box 1650
Little Rock, AR 72203-1650

Authorization to Disclose, Obtain and Use Personal Information

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the Medical Information Bureau, benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to US Able Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

I have executed this authorization intending that it will be effective on and after

(Date)

Signature

Printed Name

Return original with your claim & retain a copy of this authorization and claim form for your records.



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856 Fax (501) 235-8417
E-mail: claims@usablelife.com

Statement of Claim Short Term Disability Income Benefits Attending Physician's Statement

Instructions

1. Physician certifying disability must complete all questions, sign and date this Attending Physician's Statement.
2. Email, fax or mail the completed form to US Able Life.

ATTENDING PHYSICIAN'S STATEMENT

Neither the Employee nor the Employer should complete or alter any part of this statement.

Patient's Full Name (First, Middle, Last)		Date of Birth
Diagnosis & Concurrent Conditions 1. 2.		ICD Codes 1. 2.
<p>Disability is due to <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy If accident, provide how, when and where accident occurred _____ _____</p> <p>If Pregnancy, _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated Delivery Date _____ Date of LMP _____ Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section _____</p> <p>Date Symptoms First Appeared _____ Date Patient First Consulted You _____ Dates & Surgical Procedures (if any) _____ _____</p> <p>If hospitalized, <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Admitted _____ Date Discharged _____ Full Name of Hospital _____ Address _____ City, State, Zip Code _____ _____</p> <p>Telephone # of Hospital _____</p>		<p>Is Disability due to injury or sickness arising out of or in the course of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How long was or will patient be unable to work due to disability? From _____ Through _____ Can return to work on _____ Please list all treatment dates during the month in which the disability began _____ _____</p> <p>Date of next doctor's appointment _____</p> <p>List Restrictions and Limitations _____ _____ _____ _____</p> <p>Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____</p> <p>Describe any circumstances causing disability to be prolonged: _____ _____ _____</p>
Physician's Signature		Date
Physician's Name (Please Print/Type)		Degree
Address		Telephone
City	State	Zip Code
		Fax
FRAUD WARNING: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act.		



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Statement of Claim Short Term Disability Income Benefits Employer's Statement

Instructions

1. Employer must complete all questions, sign and date this Employer's Statement.
2. Email, fax or mail the completed form to USABLE Life.

EMPLOYER'S STATEMENT							
Employee Name (First, Middle, Last)				Date of Birth		Social Security Number	
Group Policy Number			Date of Hire		Coverage Effective Date		Weekly STD Benefit \$
Last Day Worked Date _____ # of Hours _____		Date Returned to Work <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____			Base Salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually		
Employee Regularly Works _____ Hours Per Week				Employee's Occupation			
Check Days Normally Worked?	<input type="checkbox"/> Sun	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat
If on rotation, give number of days worked per week: _____							
Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, Status of claim? <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Denial on Appeal							
Name of Worker's Compensation Carrier: _____							
Address of Worker's Compensation Carrier: _____ _____							
Employee received: Salary continuation through _____ Vacation pay through _____ Sick pay through _____							
Employer Name			Email address			Tax ID #	
Signature			Title			Date	
Name (Please print or Type)			Telephone			Fax	
Street Address		City		State		Zip Code	
FRAUD WARNING: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act.							