



P.O. Box 1271, M/S E3A
Portland, OR 97207

LifeMap Assurance Company™

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Statement of Short Term Disability

Claim Filing Instructions

This Statement of Short Term Disability (STD) includes the forms required to apply for STD benefits.
If a form is received incomplete, unsigned or undated, it will be returned to you for completion.

Have you...

1. completed in full, signed and dated the Employee's Statement?
2. signed and dated the Authorization for Release of Information?
3. had the physician treating you complete, sign and date the Attending Physician's Statement, and had it returned to you?
4. had your Employer complete, sign and date the Employer's Statement, and had it returned to you?

You are responsible for ensuring all forms are completed and returned to our office.
Forms can be sent to LifeMap via:

Email: **claims@lifemapco.com**

Fax: **1 (855) 733-4615**

Regular Mail: **LifeMap Assurance Company
Attn: Life and Disability Claims Department
PO Box 1271, M/S E3A
Portland, OR 97207-1271**

If you have any questions, please call the LifeMap Life and Disability Claims Department at 1 (800) 286-1129.

Please note, you must notify LifeMap promptly if:

- Your medical condition improves so that you would be able to work, even though you have not yet returned to work.
- You go to work in any capacity for any employer, or as a self-employed person.



Statement of Short Term Disability

Employee's Statement

LifeMapCo.com

Employee

Employee Name (Last, First, Middle Initial)			Social Security Number		
Mailing Address	Street & Number	City	State	Zip	
Home Phone Number ()	Cell Phone Number ()	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Employment

Employer Name	Employer Phone Number ()	Group Policy Number
Date you returned (or expect to return) to work on a part-time basis:	Date you returned (or expect to return) to work on a full-time basis:	
Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____		

Medical Information

Date First Treated:	First date unable to work because of disability:	
Date of injury or date first noticed symptoms of illness:	Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when	
Is your injury or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Did you file for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Yet	Workers' Compensation claim status: <input type="checkbox"/> Pending <input type="checkbox"/> Approved <input type="checkbox"/> Denied (include copy of denial letter)
Cause of Disability: <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy	If accident or illness, please explain (include date and location, if applicable)	

Attending Physician

Primary Physician:	Phone Number ()	Hospital	
Street Address	City	State	Zip
Fax Number ()		Date Admitted	Date Discharged

Other Sources of Income

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?							
Type	Amount (per week)	Date Began	Date Ended	Type	Amount (per week)	Date Began	Date Ended
Social Security (SSA)				Pension			
SSA Dependent's				State Disability			
Workers' Compensation				Other (describe):			

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Employee's Signature Date

Please complete Authorization to Obtain and Release Information form on page 4.

Statement of Short Term Disability

Insurance Fraud Warning

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California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

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

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York 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 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.

Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist, or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files, more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for 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.

Maine, Tennessee, Virginia and Washington 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.

Alaska, Kansas and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma 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.



Statement of Short Term Disability

Authorization to Obtain and Release Information

I authorize persons or entities having any records or knowledge of me or my health, including any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer:

To give Medical information including chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results and prognosis with respect to any physical or mental condition and/or treatment of me, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records which may have been acquired in the course of examination or treatment.

If the information to be disclosed contains any of the types or information listed below, additional laws relating to the use and disclosure may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information:

- _____ Drugs/Alcohol diagnosis, treatment or referral information
- _____ Mental Health information – including provider notes
- _____ HIV/AIDS information
- _____ Genetic Testing Information

And Non-medical information including education, employment history, earnings or finances, vocational evaluation reports, vocational testing and rehabilitation plans, or eligibility for other benefits including retirement benefits and retirement plan contributions (for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claim status, benefit amounts, effective dates, etc.).

To LifeMap Assurance Company (LifeMap) and to its authorized representatives.

- I understand that the information obtained by use of this authorization will be used by LifeMap and authorized representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing LifeMap solely to assist with the evaluation and adjudication of my current disability claim.
- I understand that LifeMap will release information to my employer necessary for return to work and accommodation discussions, and when performing administration for my employer’s self-funded (and not insured) disability plans.
- I understand that LifeMap complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to LifeMap may be subject to redisclosure and may no longer be protected under the Health Information Portability and Accountability Act (HIPAA).
- I understand that I have the right to revoke this authorization by notifying LifeMap in writing, of my revocation. However, such revocation is not effective to the extent that LifeMap has relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the ability of LifeMap to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.
- I acknowledge that I have read this authorization. I understand and agree that this authorization shall remain in force for the duration of my claim(s) or 12 months, whichever occurs first. A photocopy or facsimile of this authorization is as valid as the original. I understand that I, or my authorized representative, have the right to request and receive a copy of this authorization and the information to which it pertains.

▶ _____	▶ _____
Employee/Primary Insured’s Full Name (please print clearly)	Social Security Number
▶ _____	▶ _____
Employee/Primary Insured’s Signature	Date Signed

If signature is provided by legal representative (e.g. Attorney in Fact, guardian or conservator), please attach documentation of legal status.



Statement of Short Term Disability

Employer's or Administrator's Statement

LifeMapCo.com

Information about Employee

Employee Name (Last, First, Middle Initial)		Job Title	Social Security Number	Class
Date Employed:	Date Employee Last Worked Before Disability Began: (Attach payroll records to document all work, if any, since disability began)		Date of Termination: <input type="checkbox"/> N/A	
Reason for stopping work:		<input type="checkbox"/> Disability	<input type="checkbox"/> Dismissed	<input type="checkbox"/> Resigned
<input type="checkbox"/> Family Medical Leave of Absence		<input type="checkbox"/> Other Leave of Absence	<input type="checkbox"/> Layoff	<input type="checkbox"/> Retired
<input type="checkbox"/> Other Reason _____				
Date returned to work:	If part-time, number of hours worked per week:		If employee has not returned to work, estimated return to work date:	
Full-time:	Part-time:			
Are you able to accommodate release to:		Reduced hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	Modified duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please explain:				
Regularly scheduled hours per week:	Please indicate which days of the week this employee is normally scheduled to work. (circle) Sunday Monday Tuesday Wednesday Thursday Friday Saturday			
Please describe primary job duties:				
Employee's Earnings: \$			Is disability due to employment?	
Earnings prior to increase \$		Date of last increase:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
<input type="checkbox"/> hourly	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly	<input type="checkbox"/> annual	
<input type="checkbox"/> commission	<input type="checkbox"/> shift differential	<input type="checkbox"/> bonuses	<input type="checkbox"/> other:	
			Has Workers' Compensation claim been filed?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not yet	

Information about Employee's Short Term Disability Coverage

Employee Short Term Disability coverage:	What percentage of the STD premium does the Employer pay? _____%
Effective Date: Termination Date:	Are employer paid premiums included in employee's salary? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is employee contribution: <input type="checkbox"/> Pre-Tax Deduction <input type="checkbox"/> After-Tax Deduction

Other Benefits and Sources of Income

Employee Eligible for:							
Type	Amount (per week)	Date Began	Date Ended	Type	Amount (per week)	Date Began	Date Ended
Sick Pay				Vacation Pay			
Salary Continuation				State Disability			
Workers' Compensation				Other (describe):			

Additional Documentation (Please attach a copy of the following documents to this form.)

- The employee's current job description
- The employee's Workers' Compensation claim(s) and Approval/Denial Notification, if applicable

Information about Employer

Employer Name	Location Code (if applicable)	Group Policy Number
Employer Address	Street & Number	City
	State	Zip
Name and title of employer representative completing this form		Phone Number ()
		Email Address

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ _____ ▶	_____
Employer Representative's Signature	Date

Statement of Short Term Disability

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New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York 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 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.

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Statement of Short Term Disability

Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to insurance company.

Patient Information

Name of Patient (Last, First, Middle Initial)		Social Security Number	Employer Name
Height	Weight	Blood Pressure/Date Taken	<input type="checkbox"/> Left-handed <input type="checkbox"/> Right-handed

Information about Diagnosis

Diagnosis	ICD Code(s)
Symptoms	
Comorbid Conditions	
Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings)	
Date symptoms first appeared or injury occurred:	Date you recommended the patient stop working:
Patient's condition is due to: <input type="checkbox"/> Illness <input type="checkbox"/> Accident	Has patient ever had the same or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when
Is condition arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you complete Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Information about Treatment

Date of first visit for this condition:	Frequency of subsequent visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Next office visit:
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)		
Hospital Admission Date:	Hospital Discharge Date:	Was Surgery Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Procedure:		Date of Surgery:
		Surgery/Post-Operative Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Was patient treated by another provider(s) for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide dates, name and address of provider(s):		

For Pregnancy Disability Only

Date of Last Menstrual Period	Expected Date of Delivery	Actual Date of Delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
Are there any present complications or anticipated difficulties with: Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No Delivery <input type="checkbox"/> Yes <input type="checkbox"/> No Post Partum Recovery <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to any of these, please describe in detail:			

Please complete the following page.



Statement of Short Term Disability

Attending Physician's Statement (continued)

Name of Patient (Last, First, Middle Initial)

Assessment of Current Functional Ability

Describe current restrictions (activities which should not be performed by the patient):

Describe current limitations (activities which cannot be performed by the patient):

Related to a mental health condition, describe behaviors, attitudes or functional impairments that are contributing to the patient's restrictions and/or limitations:

Describe factors delaying recovery (if applicable): Malingering Exaggeration Other, please specify:

Is the patient competent to manage insurance benefits? Yes No
If no, is the patient competent to appoint someone to help manage the insurance benefits? Yes No

Return to Work Plan

Date you released patient to return to work:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Modified Duties	Number of hours per week:
	<input type="checkbox"/> Part Time	<input type="checkbox"/> Reduced Hours	

How long do you expect these limitations and restrictions to impair your patient?
 Date _____ Unable to determine, follow up appointment _____ Permanently

Please identify your recommendations for any job modifications that would enable the patient to work:

Information about Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number ()
Office Address	City	State Zip
		Fax Number ()

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 9 of this form.

▶ _____ ▶ _____
Attending Physician's Signature Date

Please return completed form to your patient.

Statement of Short Term Disability

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