BlueCross BlueShield of Texas

UTSYSTEM GFZ71778

Group Long-Term Disability Claim Form

Return to Blue Cross and Blue Shield of Texas at:
Attention Claims Department
P.O. Box 7071
Downers Grove, IL 60515

Phone Number: (866) 628-2606
Fax: (877) 404-6457

NOTE: All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

APPLICATION FOR LTD BENEFITS — Employee's Instructions

A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow Blue Cross and Blue Shield of Texas (BCBSTX) or its representative to secure additional information if necessary to make a decision on your claim.

B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

A. Attach:
- A copy of your birth certificate (only if disability is indefinite and you are over age 50)
- A copy of Social Security and other income entitlement awards; and

B. Return with all attachments, to BCBSTX at address above.

ATTENDING PHYSICIAN'S STATEMENT (APS) — Physician's Instructions

As soon as the claimant gives you this form:

A. Complete the APS on page 3 of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.

B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

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. (Not enforceable in Oregon or Virginia.)

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Employee's Claim Statement

To be Completed by Employee

CLAIMANT

1. Full Name (Last, First, Middle Init.)	2. Maiden Name	3. Alias Name	4. Benefits ID No.	5. Phone Number ( )

6. Address _____ City _____ State _____ Zip Code _____

7. Date of Birth	8. Height	9. Weight	10. Sex	11. Marital Status	12. Spouse's date of birth	13. Is spouse employed?
Mo. Day Year	ft. in.	lbs.	❑ M ❑ F	❑ Single ❑ Married ❑ Widowed ❑ Divorced	Mo. Day Year First Name	❑ Yes ❑ No

14. Number of children (Under age 19) _____

15. List names and dates of birth of unmarried children who have not finished high school.

EMPLOYMENT

16. Employer's Name _____ 17. Group Policy No. _____

18. Occupation (List the duties of your occupation at the time of disability)

19. Date of accident or date first noticed symptoms of illness: Mo. Day Year	20. I have been unable to work because of the disability since: Mo. Day Year	21. I returned to work on a part time basis on: Mo. Day Year	22. I returned to work on a full time basis on: Mo. Day Year

23. Is your accident or illness related to your occupation? ❑ Yes ❑ No

24. Have you or do you intend to file a Workers' Comp. Claim? ❑ Yes ❑ No
If "yes," explain

CLAIM HISTORY

25. Describe how and where accident occurred or describe the onset and nature of your illness.

26. Date you were first treated for your illness or injury. Mo. Day Year

27. Treated by:
Hospital: _____ (Name, Street Address, City, State, Zip Code)
Doctor: _____ (Name, Street Address, City, State, Zip Code)

28. Have you ever had the same or similar condition in the past? ❑ Yes ❑ No
If yes complete No. 29.

29. Treated by:
Hospital: _____ (Name, Street Address, City, State, Zip Code)
Doctor: _____ (Name, Street Address, City, State, Zip Code)

OTHER INCOME

30. Describe other income you are receiving:

Yes	No	Type	Amount	Date Began	Term.
❑	❑	Social Security (disability or retirement)	$_____	_____	_____
❑	❑	State disability	$_____	_____	_____
❑	❑	Retirement (normal, early or disability)	$_____	_____	_____
❑	❑	Workers' Compensation	$_____	_____	_____
❑	❑	Group disability benefits	$_____	_____	_____
❑	❑	Other (describe) _____	$_____	_____	_____

31. Have you applied, or do you plan to apply for benefits described above? ❑ Yes ❑ No

Type _____ Date application filed _____

Type _____ Date application filed _____

32. If your request for benefits is approved, do you want us to withhold amounts from each benefit for Federal Income Tax purposes? ❑ Yes ❑ No If yes, please complete and attach IRS Form W4S.

AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Blue Cross and Blue Shield of Texas's (BCBSTX) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim.
This authorization expires on the date I receive notice of BCBSTX's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by BCBSTX prior to receipt of the revocation. Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from BCBSTX. **If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, BCBSTX has the right to deny my claim.**

Signature of Employee _____ Date _____

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Attending Physicians Statement

Name of patient	Date of Birth	* Please submit bill for records with this claim.

HISTORY

(a) When did symptoms first appear or accident happen?	(b) Date patient ceased work because of disability?	(c) Has patient ever had same or similar condition? ❑ Yes If "Yes" state when and describe ❑ No
(d) Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown	(e) Names and addresses of other treating physicians	

DIAGNOSIS

(a) Diagnosis (Including complications) Please submit all office notes in regard to this condition* | (b) Subjective symptoms

(c) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings?)

TREATMENT

(a) Date of first visit | (b) Date of last visit | (c) Frequency ❑ Weekly ❑ Monthly ❑ Other (Specify)

(d) Nature of treatment (Including surgery and medications prescribed, if any)

PROGRESS

(a) Has patient ❑ Recovered? ❑ Improved? ❑ Unchanged? ❑ Retrogressed? | (b) Is patient ❑ Ambulatory? ❑ House confined? ❑ Bed confined? ❑ Hospital confined?

(c) Has patient been hospital confined? ❑ Yes ❑ No Confined from _____ through _____
If, yes, give Name and Address of Hospital:

CARDIAC

(a) Functional capacity (*American Heart Ass'n.)
❑ Class 1 (No limitation) ❑ Class 2 (Slight limitation)
❑ Class 3 (Marked limitation) ❑ Class 4 (Complete limitation)

(b) Blood Pressure (last visit) _____

IMPAIRMENT

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles).
❑ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
❑ Class 2 - Medium manual activity* (15-30%)
❑ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
❑ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
❑ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)
Remarks:

(b) Mental Impairments (If applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?
❑ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
❑ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
❑ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
❑ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
❑ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
Remarks:

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ❑ Yes ❑ No ANY OTHER WORK ❑ Yes ❑ No | (b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future?
❑ 1 Mo. ❑ 1-3 Mo. ❑ 3-6 Mos. ❑ Never. Applies To: ❑ Patient's job ❑ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ❑ Yes ❑ No ANY OTHER WORK ❑ Yes ❑ No | (b) Can present job be modified to allow for handling with impairment? ❑ Yes ❑ No

(c) When could trial employment commence? Date _____ (PATIENT'S JOB) ❑ Full-time ❑ Part-time Date _____ (ANY OTHER WORK) ❑ Full-time ❑ Part-time

REMARKS

(Limitations, Therapy, etc.)

Name (Attending Physician) *Print*	Degree	Telephone ( ) Fax #: ( )
Street Address	City or Town	State / Zip Code
Signature	Date	

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

FOR APPLICATIONS AND CLAIMS:

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.

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

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.

Louisiana: 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.

Maine & 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.

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, with intent to injure, defraud or deceive any insurer, makes a 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

Virginia: 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.

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.

California: 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.

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 or 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 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:

Massachusetts: 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.

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.