# CONTINUING DISABILITY CLAIM FORM

**FAX TO 1.800.880.9325**
Questions? Call 1.800.325.4368
24 Hours A Day/7 Days a Week
**Please Allow Two Weeks Processing Time**

**OR YOU MAY MAIL TO:**
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
Attn.: DISABILITY BENEFITS
P. O. BOX 100195
COLUMBIA, SOUTH CAROLINA 29202-3195

*If the address given below has changed since your last claim please mark box with an "x".* ☐

## SECTION 1 — TO BE COMPLETED BY POLICYHOLDER

| Policyholder name | Claimant name | ☐ Male ☐ Female | Claim Number (*see payment letter*) or Policy Number |
|---|---|---|---|
| Address (Street) | | Policyholder Social Security Number | Claimant Birthdate (MM/DD/YYYY) |
| City / State / Zip Code | | | |
| Policyholder Email Address | | Home Telephone ( ) | Work Telephone ( ) |
| Date and Description of Injury/Sickness | | Did your injuries occur while working for wage or profit? ☐ Yes ☐ No | |
| List dates (MM/DD/YYYY) unable to work<br>From: To: | | If not employed, list dates (MM/DD/YYYY) of house confinement*:<br>From: To: | |
| Have you returned to your place of employment? Date Returned to Work (MM/DD/YYYY)<br>☐ Yes, ☐ Full-time ☐ Part-time ☐ No | | **house confinement means unable to do normal daily activities.* | |

## SECTION 2 — TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

| Dates (MM/DD/YYYY) Employee unable to work<br>From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m. | | Date Employee returned to his/her primary duties<br>Date (MM/DD/YYYY) ☐ a.m. ☐ p.m. Part-time ☐ Full-time ☐ | |
|---|---|---|---|
| Employee's position and primary duties | | | |
| Signed By | Title | Date (MM/DD/YYYY) | Employer's Telephone Number ( ) |

## SECTION 3 — TO BE COMPLETED BY PHYSICIAN

What is this patient's current primary disabling condition? ______________________________

| Symptoms: | Objective Findings: |
|---|---|
| Are there secondary conditions contributing to the disability?<br>☐ Yes ☐ No | If yes, what are they and would the patient be disabled without regards to these secondary conditions? |

List any test(s) performed and submit a copy of the results.

List any surgeries performed and submit a copy of the operative reports.

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

What is your prognosis of recovery?

| How soon do you expect significant improvement in the patient's medical condition?<br>☐ 1-2 months ☐ 3-4 months ☐ 5-6 months ☐ more than 6 months | | Estimated Return to Work Date (MM/DD/YYYY) |
|---|---|---|
| Is this patient permanently disabled?<br>☐ Yes ☐ No | Is patient considered to be house confined and/or unable to perform 2 out of 5 activities of daily living*?<br>☐ Yes ☐ No<br>**dressing, eating, transferring, toileting and meal preparation.* | List dates (MM/DD/YYYY) of house confinement.*<br>**house confinement means unable to do normal daily activities.* |
| Dates (MM/DD/YYYY) of Total Disability<br>From: To: | Dates (MM/DD/YYYY) of Partial Disability<br>From: To: | Patient's return to work date (MM/DD/YYYY) |

| Dates (MM/DD/YYYY) of Office visits (Last 3 months) | | Dates (MM/DD/YYYY) of Hospitalization (Last 3 months) | |
|---|---|---|---|
| Is patient currently being treated by any other practitioner or therapist? If so, list name and address. | | Name and Address of Hospital | |
| Signature of Physician or Supplier | Date (MM/DD/YYYY) | Physician's Specialty | |
| Telephone Number ( ) | Doctor's Fax Number ( ) | Tax ID or SSN | |
| Physician/Supplier Group Name | | Patient Number | Submit charges with assignment if applicable. |
| Address | | | |

**PLEASE SIGN AND RETURN THE ENCLOSED AUTHORIZATION AND CERTIFICATION BELOW TO AVOID DELAY.**

## CERTIFICATION

Policyholder/Employee's Name______________________________ Social Security Number______________

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the "Claim Fraud Warning and State Versions" form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. 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.

___/___/___
Date (MM/DD/YYYY) ______________________ PATIENT SIGNATURE ______________________ POLICYHOLDER/EMPLOYEE SIGNATURE

# Continuing Disability Claim Form

**Do Not Use This Form If This Is The FIRST Time You Have Filed For Benefits For THIS Injury/Sickness**

**Colonial Life & Accident Insurance Company**
**1200 Colonial Life Boulevard**
**P. O. Box 100195, Columbia, South Carolina 29202**
**1-800-325-4368 or Fax 1-800-880-9325**