HOW TO FILE YOUR DISABILITY CLAIM

We understand you file claims during difficult times, and Transamerica is committed to helping you care for your health without sacrificing your financial future. We know these forms ask for a lot of information, but it's all important for processing your claim smoothly.

Transamerica requires **four forms** for everyone who submits a disability claim. These are all included and clearly labeled in this document:

1. The **Employee's Statement** is the core document of your claim. It describes your claim and captures critical information about you.
2. The **Authorization for Release of Information** lets us access your personal health information.
3. The **Employer's Statement** is a form your employer completes to describe your employment history at the company and the nature of your work.
4. The **Attending Physician's Statement** is a document you give to the doctor who provided the treatment related to your claim. Take a moment to verify the doctor answered all the questions and signed the form.

If you have any questions about this form, please call toll-free 888-862-6256.

Send all four completed forms to us in a way that's easiest for you:

email: send scanned documents to TAclaims@disabilityrms.com

mail: Transamerica Claims
300 Southborough Drive Suite 200
South Portland ME 04106

fax: 866-376-9480

Questions?

EMAIL: TAclaims@disabilityrms.com

CALL: 888-862-6256 (weekdays 8 am – 5pm ET)

1 EMPLOYEE'S STATEMENT

Disability claim type: ☐ long-term ☐ short-term

Employee name: _____

Employer name: _____ Group number: _____

You must complete the Employee's Statement for any disability claim you file. It describes your claim and captures critical information about you.

Your name			Social Security Number — —
Your address Street & number		City State	ZIP
Phone ( )	Email	Date of birth ____/____/____	☐ Male ☐ Female
☐ Right-handed ☐ Left -handed	Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Is your spouse employed? ☐ Yes ☐ No	Number of dependent children _____
Names and birth dates of spouse and dependent children			
How many hours were you regularly working per week with your present employer? _____ hours	Gross annual salary (in the 12 months prior to your disability, for this employer only) $ _____	Please indicate how you are paid (check all that apply): ☐ hourly ☐ salaried ☐ other _____ ☐ includes commissions ☐ includes bonuses	
Name of your employer		Employer's phone ( )	
Employer's address Street & number		City State	ZIP
Your occupation & job title	List the essential duties of your job at the time of disability		
Date of injury, or when you first noticed symptoms of sickness: ____/____/____	Date since you have been unable to work because of disability: ____/____/____	Date you returned to work on a part-time basis (if applicable): ____/____/____	Date you returned to work on a full-time basis (if applicable): ____/____/____
Is your injury or sickness related to your occupation? ☐ Yes ☐ No	If "yes" explain: Did you file for workers' compensation? ☐ Yes ☐ No		
Describe how and where your injury occurred or describe the onset and nature of your medical condition (including symptoms). If you need more space, please attach a separate sheet of paper.			
Date first treated: ____/____/____	If you were hospital confined, please provide the name and address of the hospital: _____ Hospital name Street & number City State ZIP Confined from ____/____/____ through ____/____/____		
Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, when? ____/____/____	Who were you treated by? _____ Hospital name Street & number City State ZIP _____ Doctor name Street & number City State ZIP		

1 EMPLOYEE'S STATEMENT

Employee name: _____

Employer name: _____ Group number: _____

If you're filing this claim for pregnancy, are there any present complications or anticipated difficulties in connection with:

Pregnancy ☐ Yes ☐ No Date of last menstrual period: ____/____/____ Expected date of delivery: ____/____/____

Delivery ☐ Yes ☐ No Actual date of delivery : ____/____/____ ☐ Vaginal ☐ C-Section

Post-Partum ☐ Yes ☐ No

If "Yes" to any of the above, please specify in detail:

As a result of this disability, have you, your spouse, or any of your dependents received income from any of the following?

Yes	No	Type	Amount	Starting date	Ending date	Weekly	Monthly
☐	☐	Sick pay	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Salary continuance	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Association/society disability income plan	$_____	___/___/___	___/___/___	☐	☐
☐	☐	No fault	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Unemployment compensation disability	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Social Security (disability or retirement)	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Retirement income (normal, early, disability)	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Other disability benefits	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Other (describe): _____	$_____	___/___/___	___/___/___	☐	☐

Have you applied, or do you plan to apply, for any of the benefits described above? ☐ Yes ☐ No

Type _____ Date application filed ____/____/____

Type _____ Date application filed ____/____/____

If your request for benefits is approved, do you want Transamerica to withhold federal income taxes?

☐ Yes ☐ No If yes, tell us how much to withhold amount: $ _____ ($88 minimum per month)

Don't forget to sign and date this Employee's Statement on the next page: we can't evaluate your claim without your signature!

FRAUD NOTICE

Unless specific state language is provided below, the following general fraud notice applies: 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.

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, Louisiana, New Mexico, West Virginia. 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 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."

Delaware, Florida, Idaho, Indiana, Oklahoma. 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.

District of Columbia, Colorado. 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.

Kentucky. 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.

1 EMPLOYEE'S STATEMENT

Employee name: _____

Employer name: _____ Group number: _____

Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.
Maryland, Alabama, Rhode Island and Texas. Any person who knowingly or willfully 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.
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.
Ohio. Any person who, with 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.
New York. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

_____ _____

Signature of employee Date

2 AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization complies with the HIPAA Privacy Rule, and it's required for all claims. A copy of this authorization will be considered as valid as the original. Please sign below.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Workers Compensation, State Disability, pension, credit, earnings and employment history), to give any and all such information to authorized representatives of Transamerica, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS* information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Transamerica, and the above-described 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, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Transamerica may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Transamerica in writing, of my revocation. However, such revocation is not effective to the extent that Transamerica has relied previously upon this authorization for the use or disclosure of my protected health information. I understand Transamerica cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of, or my failure to sign this authorization may impair Transamerica's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

* **California residents:** This authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released. **Connecticut, Maine, or Massachusetts residents:** This authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released. **Vermont residents:** This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Transamerica to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Transamerica shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Employee name _____ Date of birth _____

Signature of employee _____ Date signed _____

If signed by an authorized representative, attach verification of their identity and describe their authority below:

3 EMPLOYER'S STATEMENT

After your employer completes this, submit it with the other parts of your claim.

Name of employee	Occupation	Is disability due to employment? ☐ Yes ☐ No

Date employed	Date insured	Date last worked	Reason for stopping work
___/___/___	___/___/___	___/___/___	☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family medical leave of absence ☐ Other leave of absence ☐ 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:	Date employment terminated	Date disability insurance terminated
___/___/___ ☐ Full time ☐ Part time		___/___/___	___/___/___	___/___/___

Required number of hours per week:	Gross annual salary: (during the 12 months prior to employee's disability)	Please indicate how the employee is paid (check all that apply):
_____ hours	$ _____	☐ Hourly ☐ Salaried ☐ Other _____ ☐ Includes commissions ☐ Includes bonuses

Is employee subject to FICA tax? ☐ Yes ☐ No If yes is employee subject to... ☐ Full FICA tax? ☐ Medicare only?	Percent contribution to premium for this disability plan (in policy year of disability): Employee ☐ 100% ☐ Other _____% Contribution is: ☐ Pre-tax ☐ After-tax Employer ☐ 100% ☐ Other _____%

Which of the following is the employee eligible for?

Yes	No	Type	Amount	Starting date	Ending date	Weekly	Monthly
☐	☐	Sick pay	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Salary continuance	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Workers' compensation	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Association/society disability income plan	$_____	___/___/___	___/___/___	☐	☐
☐	☐	No fault	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Unemployment compensation disability	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Social Security (disability or retirement)	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Retirement income (normal, early, disability)	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Other disability benefits	$_____	___/___/___	___/___/___	☐	☐
☐	☐	Other (describe): _____	$_____	___/___/___	___/___/___	☐	☐

Please attach a copy of these employee documents to this form:

- Workers' compensation claim(s) and approval/denial notification
- Prior year's W-2 form (if W-2 is unavailable, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability)
- Current job description

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I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

_____ Name of policyholder (company)

_____ Print name & title of official representative

_____ Mailing address of policyholder (company)

_____ **Signature**

_____ **Date**

_____ Phone

_____ Fax

4 ATTENDING PHYSICIAN'S STATEMENT

After your doctor completes this, submit it with the other parts of your claim.

Full name of patient		☐ Male ☐Female	Date of birth
Height: _____ Weight: _____	Blood pressure (last visit) Systolic _____ Diastolic _____	☐ Left-handed ☐ Right-handed	____/____/____

1. HISTORY

a. Is condition due to ☐ accident? ☐ sickness?
b. When did symptoms first appear, or injury first occur? Month_____ Day _____ Year _____
c. Date patient was unable to work because of impairment: Month_____ Day _____ Year _____
d. Has patient ever had same or similar condition?
☐ Yes ☐ No If yes, state when and describe:

e. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Please explain:

f. Was this patient referred to you? ☐ Yes ☐ No If yes: by whom, and what is their specialty?

g. Have you referred this patient to another treating provider? ☐ Yes ☐ No If yes: to whom, and what is their specialty?

2. DIAGNOSIS

a. Diagnosis impacting function: _____ ICD Code(s) _____
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)

b. Secondary diagnosis impacting function: _____ ICD Code(s) _____
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency)

c. Subjective symptoms:

d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings):

3. FOR PREGNANCY DISABILITY ONLY

Are there any present complications or anticipated difficulties in connection with the following?

a. Pregnancy ☐ Yes ☐ No Date of last menstrual period: ___/___/___ Expected date of delivery ___/___/___
b. Delivery ☐ Yes ☐ No Actual date of delivery: ___/___/___ ☐ Vaginal ☐ C-section
c. Post-partum ☐ Yes ☐ No

If yes to any of these, please specify in detail:

4. DATES OF TREATMENT FOR THIS CONDITION

a. Date of first visit Month _____ Day _____ Year _____
b. Date of last visit Month _____ Day _____ Year _____
c. Next office visit Month _____ Day _____ Year _____
d. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify):

5. PROGRESS

a. Has patient ... ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
b. Is patient ... ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

If hospital confined, give name and address of hospital:
Confined from _____/_____/_____ through _____/_____/_____

6. CARDIAC Functional capacity per American Heart Association standards (if applicable):
☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

4 ATTENDING PHYSICIAN'S STATEMENT

Employee name: _____

7. CURRENT FUNCTIONAL ABILITY

a. In an 8-hour day, what is the maximum number of hours your patient could perform each of these levels of activity?

____ hours sedentary activity	10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours
____ hours light activity	20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours
____ hours medium activity	50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing
____ hours heavy activity	100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing

b. Please check appropriate box:

	Occasionally <33%	Frequently 33–66%	Continuously >66%
Bending	☐	☐	☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push/pull	☐ pounds: _____	☐ pounds: _____	☐ pounds: _____
Lifting	☐ pounds: _____	☐ pounds: _____	☐ pounds: _____

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific.

d. Upper extremity function — please indicate upper extremity functional capabilities:

Simple grasp	☐ Left	☐ Right	Comments: _____
Pinch	☐ Left	☐ Right	Comments: _____
Fine manipulation	☐ Left	☐ Right	Comments: _____
Power grip	☐ Left	☐ Right	Comments: _____
Repetitive motion	☐ Left	☐ Right	Comments: _____

8. MENTAL HEALTH ABILITY (if applicable)

What behavior, attitudes, or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

9. RETURN-TO-WORK PLAN

a. Have you discussed a return-to-work plan with your patient? ☐ Yes ☐No

b. The date you released patient to return to work: Month _____ Day _____ Year _____

☐ Full-time ☐ Reduced hours Number of hours: _____

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

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_____ _____

Attending physician's signature | Date

_____ _____ _____

Attending physician's name (please print) | Degree / specialty | Tax ID

_____ _____ _____

Office address | Phone | Fax