



## Short Term Disability Claim Form Employee Questionnaire

1. Name		2. Date of Birth	
3. Address			
4. Telephone Number		5. E-mail Address	
6. Group Number & Division		7. Certificate Number / Social Security Number	
8. Current job title with your employer		9. What is the first date you were unable to work because of this disability?	
10. Describe the daily duties of your job (Example: My job requires that I am kneeling/squatting 80% of the day and the remaining 20% walking or sitting.)			
11. Have you been continuously totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what date did you return to work? <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time			
12. Have you been continuously partially disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what date did you return to work?			
13. Did you use sick time or vacation time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the specific dates of sick or vacation time used?			
14. Is this disability injury related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe how, when and where the injury occurred.			
15. Did your illness or injury occur as a result of engaging in any activity for pay, profit or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. If yes, please provide the name and address of the employer where the illness or injury occurred.			
17. If your claim was approved or denied by the workers compensation carrier, <b>please provide a copy of the approval or denial letter with your claim.</b>			
18. Are you receiving any income(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. If yes, please provide the following information:			
A. Social Security Disability Income: \$ _____			
B. Workers Compensation Income: \$ _____			
C. Other incomes (including incomes from other insurance policies): \$ _____			
D. If you are receiving any income, please provide the names and addresses, policy number and the date payments began and/or ceased?			
_____			
_____			
_____			
_____			
_____			
_____			

**Short Term Disability Claim Form - Employee Questionnaire**

20. Prior to this disability claim, did you receive a diagnosis, medical care, services, treatment, advice or recommendations for this disability?  Yes  No

21. If yes, what date did you receive
- A. Diagnosis \_\_\_\_\_
  - B. Medical Care \_\_\_\_\_
  - C. Services \_\_\_\_\_
  - D. Treatment \_\_\_\_\_
  - E. Advice \_\_\_\_\_
  - F. Recommendations \_\_\_\_\_

22. Who were your treating physicians (please include addresses and telephone numbers)

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**FEDERAL INCOME TAX WITHHOLDING**

23. Please check the box below if you wish us to withhold Federal Income Tax from your available disability benefit\*. The minimum amount you may request be withheld is **\$20 per week**.

- I request TruAssure Insurance Company (TruAssure) or its authorized representative to withhold \$ \_\_\_\_\_ per week from my available Short Term Disability Benefit payments for my Federal Income Taxes. I understand that my request is good for the duration of my claim or until 7 days after TruAssure receives my written request for a change or discontinuance.

*\*We are required by law to withhold Federal Income Taxes from insured groups that are administered on a self-funded basis. We will deduct Federal Income Taxes at a rate of 28% of your gross benefit.*

**AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION  
(This Authorization complies with the HIPAA Privacy Rule)**

I CERTIFY that the above statements are true, complete and correct to the best of my knowledge and belief.

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to TruAssure Insurance Company, its employees, agents or representatives (TruAssure). "Information" may include my entire medical record, diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report or any other medical or non-medical information about me.

The information to be disclosed under this Authorization may be used by TruAssure to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with TruAssure.

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**AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION (CON'T)**

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to TruAssure. I am aware that my revocation will not be effective until received by TruAssure and will not be effective regarding the uses and/or disclosures of my Information that TruAssure has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides TruAssure with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent TruAssure from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

Signature of Claimant or Personal Representative\* \_\_\_\_\_

Date \_\_\_\_\_

\*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation):

\_\_\_\_\_

**MAIL FORM TO:           ATTN: Disability Claims  
TruAssure Insurance Company  
801 Ogden Avenue  
Lisle, IL 60532**



## Short Term Disability Claim Form

### Attending Physician's Statement

24. Patient's Name \_\_\_\_\_

25. Date you first attended patient \_\_\_\_\_

26. Date you last attended patient \_\_\_\_\_

27. Date sickness or injury began \_\_\_\_\_

28. Diagnosis code \_\_\_\_\_

29. ICD-9 code \_\_\_\_\_

30. Description \_\_\_\_\_

31. If patient was hospitalized, provide admit and discharge dates

Admit \_\_\_\_\_ Discharge \_\_\_\_\_

32. Is this illness or injury work related?  Yes  No

33. A. Is this illness or injury intentionally self-inflicted or attempted suicide?  Yes  No

B. If yes, please give details \_\_\_\_\_

34. Is this illness or injury resulting from weight control or treatment of obesity not caused by an organic condition?  Yes  No

35. Please describe your objective findings \_\_\_\_\_

36. Has surgery been done?  Yes  No If yes, what procedure was performed? \_\_\_\_\_

Date of surgery? \_\_\_\_\_

37. To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment, advice or recommendations for this condition prior to this disability onset?  Yes  No

If Yes, please provide the name, address and telephone number of the referring physician. \_\_\_\_\_

38. Physical restrictions/limitations (as defined in the 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%)

What are the patient's restrictions/limitations? \_\_\_\_\_

39. Mental impairments (if applicable)

- 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 or engage in 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 physiological, psychological, personal and social adjustment (severe limitations).

**If this claim is for maternity, refer to page 2, MATERNITY; If this claim is for a total disability, refer to page 2, TOTAL DISABILITY; If this claim is for a partial disability, refer to page 2, PARTIAL DISABILITY.**

## Short Term Disability Claim Form - Attending Physician's Statement

### TOTAL DISABILITY

40. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

41. What date did he/she become totally disabled (continuously unable to perform the functions of his/her occupation or to work for wage or profit)?

42. A. Has the patient been continuously totally disabled since this date?  Yes  No

B. If no, what date was the patient no longer totally disabled?

43. What is the patient's expected return to work date?

44. Is the patient a candidate for partial disability?  Yes  No If yes, refer to partial disability section below.

### MATERNITY

45. Is this disability due to pregnancy?  Yes  No

46. If disability is prior to delivery, what are the complicating factors (be specific) and expected date of delivery?

47. What was the patient's date of delivery?

48. Type of delivery?  Vaginal  C-section

49. What is the patient's expected return to work date?

### PARTIAL DISABILITY

50. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

51. What date did he/she become partially disabled?

52. What is the number of days or hours the patient can resume part-time work?

53. What is the patient's expected return to work date on a full-time basis?

### PHYSICIAN INFORMATION

54. Physician Name (Please print)

Physician Address

Physician Telephone Number

54. Date Physician's Signature

**MAIL FORM TO:** **ATTN: Disability Claims**  
**TruAssure Insurance Company**  
**801 Ogden Avenue**  
**Lisle, IL 60532**



## Short Term Disability Claim Form

### Employer Questionnaire

55. Employee Name

56. Employee Certificate Number/SSN

57. Group/Policy Number

58. Date of Hire

59. What was the last day worked and number of hours worked that day?

60. A. Was sick time, vacation time or salary continuation paid?  Yes  No

B. If yes, provide the specific dates paid.

61. A. Did the sickness or injury arise out of or in the course of employment?  Yes  No

B. If yes, has a workers compensation claim been filed?  Yes  No *If the claim was denied by your workers compensation carrier, provide a copy of the DENIAL letter with this claim.*

C. If no, please explain

62. Is your employee still absent?  Yes  No

63. A. If employee is partially disabled, are you able to make reasonable accommodations?  Yes  No

(Example: An employee's job requires daily lifting and carrying of objects in excess of 25 lbs. If the physician releases the employee to return to work with a restriction of lifting and carrying a maximum of 10 lbs. for 3 weeks, can you reasonably accommodate this restriction?)

B. If no, provide the return to work date \_\_\_\_\_  Full-time  Part-time (If you have partial disability coverage and the employee returned to work part-time, you must include the number of hours and days worked, as well as the earned wages during the week. This information MUST be sent, faxed or emailed to TruAssure at the end of each week.)

64. Employee's average weekly wage?

65. Employee's average hours per week?

66. Was the employee insured under your prior STD policy?  Yes  No

67. If yes, what was the employee's effective date of the prior policy?

68. Job title (**IMPORTANT: PLEASE ATTACH JOB DESCRIPTION**)

69. Do you consider your employee able to perform (complete based upon employee's job)?

- Sedentary Work: Lift 10 lbs. maximum and occasionally carry small objects
- Light Work: Lift 20 lbs. maximum and frequently lift/carry up to 10 lbs.
- Medium Work: Lift 50 lbs. maximum and frequently lift/carry up to 25 lbs.
- Heavy Work: Lift 100 lbs. maximum and frequently lift/carry up to 50 lbs.
- Very Heavy Work: Lift in excess of 100 lbs. and frequently lift/carry 50 lbs.

70. Does the employee perform the following tasks?

	Never	Occasionally (1-33%)	Frequently (34-56%)	Continuously (57-100%)
Push/pull-while seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/pull-while standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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71. Assuming an 8-hour workday with two fifteen-minute breaks and 1/2-hour meal break; I expect this employee to be able to:  
(circle the number of hours for each activity.)

Sit	1	2	3	4	5	6	7	8	Continuously	With Rest
Stand	1	2	3	4	5	6	7	8	Continuously	With Rest
Walk	1	2	3	4	5	6	7	8	Continuously	With Rest
Alternately Sit/Stand	1	2	3	4	5	6	7	8	Continuously	With Rest

Comments: \_\_\_\_\_

### FICA TAX WITHHOLDING INFORMATION

72. Are employee's wages subject to the Social Security Act or Railroad Retirement Act?  Yes  No

73. Indicate employee's Social Security Identification Number as shown on your employment records:

74. A. Do you contribute 100% of the premium for the employee's short term disability coverage?  Yes  No

B. If no, what percentage of the premium for such coverage is contributed by you \_\_\_\_\_ %; by the employee \_\_\_\_\_ %

75. Is the employee's percentage subject to a cafeteria plan?  Yes  No

76. Employer Name

77. Employer Address

78. Employer Telephone Number

79. Employer E-mail Address

80. Date

Signature of Authorized Representative

Name of Authorized Representative (Please print)

Title

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