SHORT TERM DISABILITY CLAIM FORM

Before You Start:

Overpayment Notice: Should you become overpaid at anytime during the duration of this claim we, Triada Health, will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Triada Health to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

I

INFORMATION WE NEED FROM YOU:

Group Number: _____ Member Number _____ Hours Worked per Week: _____

Your Address: _____ Social Security Number: _____ Phone Number: _____

_____

(Number & Street) City State Zip

E-mail Address: _____

Date of Birth: _____ ☐ M ☐ F Height: _____ Weight: _____

Date of Disability (1st Day Absent): _____ Date First Treated: _____ Est. Return to Work Date: _____

Describe Injury or Sickness Completely (If injury, describe how accident occurred):

_____

_____

Was the disability work related? ☐ Yes ☐ No Have You Filed for Worker's Compensation? ☐ Yes ☐ No

Was this disability related to a motor vehicle accident or is another third party liable? ☐ Yes ☐ No

Name of Physician Who First Treated this Condition: _____

Address of Physician Who First Treated this Condition: _____

Other Income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Worker's Compensation			
State Disability			
Other			

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge.

Please refer to the "Fraud Warning Notices" insert for your state.

Insured's Signature: _____ Date: _____

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Telephone: 1-877-387-4232 Fax: 281-741-1830

INFORMATION WE NEED FROM YOUR EMPLOYER:

Company Name: _____ Group Number: _____ Member Number: _____

Class No. or Description: _____ Division/Location No. or Description: _____

Employer Address: _____
(Number & Street) City State Zip

E-mail Address: _____

Employee's Name: _____ Employee's Phone Number: _____

Employee Address: _____
(Number & Street) City State Zip

Weekly earnings as defined by the Plan: _____ (Please note: Benefits will be calculated based on the premium received.)

Number of hours worked weekly: _____

Was this disability caused by employment? ☐ Yes ☐ No Has worker's compensation claim been filed? ☐ Yes ☐ No

Does the Employee contribute toward their disability premium? ☐ Yes ☐ No

If yes, what percent is paid by the Employee? _____ Is it Pre-tax or Post-tax? _____

Employee's payroll classification: ☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly ☐ Union ☐ Non-Union ☐ Other

How was the Employee paid? _____

Is the Employee continuing to receive compensation or pay since their last day of work? ☐ Yes ☐ No

If yes, what is the weekly amount of the type of compensation being received and the period payable?

Amount		Salary Continuation	Start		End		Amount		Vacation	Start		End	
Amount		Sick Leave	Start		End		Amount		PTO	Start		End	
Amount		Severance	Start		End		Amount		Other	Start		End	

If other is marked, please describe: _____

Date of Hire: _____ Date Covered Under This Plan: _____

Employee's Job Title: _____ Last Day at Work: _____

What was the Employee's employment status on their first day absent? _____

Has the employee returned to work? ☐ Yes ☐ No

If yes, when did they return? _____ If no, what is the estimated return-to-work date? _____

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Name of Person Completing this Form: _____ Title: _____

Phone Number: _____ Fax Number: _____ E-mail Address: _____

Signature of Person Completing this Form: _____ Date: _____

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INFORMATION WE NEED FROM YOUR PHYSICIAN:

Employer Name: _____ Group Number: _____

Name of Patient (Last, First, MI, Please Print): _____

Patient Date of Birth: _____ Employee Phone #: _____

Employee Address: _____
(Number & Street) City State Zip

Diagnoses: _____ ICD-9 Code(s): _____

Symptoms: _____ Date Symptoms First Appeared: _____

Initial Date of Treatment: _____ Last Date of Treatment: _____ Next Date of Treatment: _____

Is disability due to: ☐ Accident/Injury ☐ Sickness Is disability work related? ☐ Yes ☐ No

If applicable, list the surgical procedure(s) - Describe fully and provide dates if any.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period:	Expected Delivery Date:	Expected Delivery Type: ☐ Vaginal ☐ Cesarean Section
Actual Date of Delivery	Actual Type of Delivery: ☐ Vaginal ☐ Cesarean Section	

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room?	☐ Yes ☐ No	Date Treated	Name of Hospital	Name of Physician
Did another physician treat or will be treating the patient?	☐ Yes ☐ No	Date Treated	Physician's Name and Address	
Was the patient Hospital Confined?	☐ Yes ☐ No	Date Confined in Hospital: From: _____ To: _____		Name of Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center?	☐ Yes ☐ No	Date of Surgery	Name of Facility	

Describe the Patient's Physical and/or mental limitations and restrictions (functional capacity):

Factors Delaying Recovery (if applicable):

How long do you expect these limitations and restrictions to impair your patient? _____

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Name of Physician Completing this Form: _____ Specialty: _____

Address: _____
(Number & Street) City State Zip

Phone Number: _____ Fax Number: _____ Physician Tax ID: _____

Signature of Person Completing this Form: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

I authorize the disclosure of health information regarding, or related to:

Name: _____ Date of Birth: _____ Policy #: _____ Claim #:_____

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations such as MIB, Inc. ("MIB"), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Triada Health, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization to administer the above referenced individual's health insurance coverage. I authorize Triada Health or its reinsurers to make a brief report of my protected health information to MIB.

A photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below.

I understand that my providers may not refuse to provide treatment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Triada Health may not be able to make any benefit payments. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Triada Health, 10713 W. Sam Houston Pkwy N., Suite 100, Houston, TX, 77064. Attention: Privacy Officer.

I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and once re-disclosed, may no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that I will receive a signed copy of this Authorization

Signature of Individual or Individual's Personal Representative: _____ Date: _____

If signed by the individual's personal representative, e.g. a parent on behalf of a child, describe your authority to sign on the behalf of the individual:

NOTICE OF INFORMATION PRIVACY PRACTICES

Protecting Your Information

TRIADA HEALTH (*herein referred to as "we," "us," "our"*) maintains physical, electronic and procedural safeguards to protect your nonpublic personal information.

Collecting Information

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- Information we collect may include all the information you share with us, including for example, your:
  - name
  - address
  - telephone number
  - date of birth
  - social security number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us

- We may also collect data we receive from other sources, as allowed by law, which may include:
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employes, such as group insurance
  - information to asssist us in complying with state and federal laws

Sharing Information

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- We may share information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf

- We may also share your information with:
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

Sharing Information

You have the right to request access to all the information we have on you. You must make your request in writing to the address below.

Admentments to Your Information

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

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FRAUD WARNING NOTICES FOR CLAIMS
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

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 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.

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.

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.

DISTRICT OF COLUMBIA: 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any 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.

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.

LOUISANA: 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: 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: 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 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 NH Rev. Stat. Ann. §638:20.

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FRAUD WARNING NOTICES FOR CLAIMS
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

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.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of 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 the stated value of the claim for each such violation.

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.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: 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 may be guilty of insurance fraud.

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 are 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, incom-plete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

VIRGINIA: ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED THE STATE LAW.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance com-pany for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

ALL OTHER STATES: 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.

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