Atlantic American Employee Benefits Claims Department
PO Box 105652, Atlanta, GA 30348
Phone: (866) 458-7499
Fax: (404) 926-4036
Email: claims@atlam.com

A Guide for Successfully Completing the Group Short-Term Disability Claim Form

Atlantic American Employee Benefits appreciates the opportunity to provide valuable income protection. We rely on the information provided on the following forms to effectively determine the eligibility of group short-term disability claim for benefits.

This guide provides information and instruction to help successfully complete and submit all required forms. Please consult your employer/benefits administrator if you need assistance in providing information.

Important Tips for Submission

- Prior to submission, make sure all questions are answered completely and accurately. If information is missing or cannot be read, the processing of the claim for benefits could be delayed.
- The following guidelines provide information to help successfully complete the form.

Guidelines for Claim Form

This section is to be completed by you, the Employee. Dates should include the month, day and year. In order to be considered complete, the form must be signed by you.

- Policy Number will consist of ten characters which will come after “005”.
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Height should be provided in feet and inches.
- Weight should be provided in pounds.
- ‘Date of Disability’ indicates the first day at which you became unable to work because of the disabling condition.
- ‘Date First Treated’ indicates the date you first sought medical care because of the disabling condition.
- Motor Vehicle Accident Report (if applicable)—If the disability was a result of an auto accident, you are required to submit a copy of the police report.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer

Both authorizations are to be completed by you, the Employee. Dates should include the month, day and year. In order to be considered complete, the form must be signed by you or your legal representative.

- Medical records from your providers may be needed in order to make a determination on your claim. A completed authorization form will be needed to obtain them. To avoid any additional delays in the claim, please be sure to complete and submit the authorization forms with your claim application.
- By signing the authorizations, you are applying for short-term disability benefits and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Employer’s Statement

This section is to be completed by the Employer. Dates should include the month, day and year. In order to be considered complete, the form must be signed by the Employer.

- ‘Date Covered Under This Plan’ indicates the date in which the Employee’s coverage became effective.
- Please include copy of Employee’s enrollment form, if applicable.
- For an accident or injury related to on the job, a copy of the workers’ compensation report is required.

Guidelines for Attending Physician’s Statement

This section is to be completed by the Attending Physician. Dates should include the month, day and year. In order to be considered complete, the form must be signed by the Attending Physician.

ATLANTIC AMERICAN
Employee Benefits

Mail To: **Atlantic American Employee Benefits**
PO Box 105652, Atlanta, GA 30348-5652
Toll Free Claim Number: (866) 458-7499
aaemployeebenefits.com

SHORT TERM DISABILITY CLAIM FORM

Has a Claim been filed before for this loss? .....❒ **Yes** ❒ **No**

Section 1 – Employee Information

Current Employee Name (First, Middle & Last)	Policy #	Job Title	Hours Worked per week
Employee Address	Employee City	Employee State	Employee Zip

Employee Home Telephone #	Employee Cellular Telephone #	Employee SSN

Employee Email Address	Employee Date of birth	Employee Height	Employee Weight

Section 2 – Details of Disability

Date of Disability		
Nature of disability and when symptoms first appeared or describe how and where accident occurred (including date(s) and times)		
Date First Unable to Work	Date First Treated	Estimated Return to Work Date
Was disability work related? ❒ Yes ❒ No	Have you returned to your main duties of your occupation? ❒ Yes ❒ No	Hours worked per week (after disability)

Section 3 – List all Physicians who have treated you for this condition

Name	Street Address, City/State/Zip	Phone #
Name	Street Address, City/State/Zip	Phone #
Name	Street Address, City/State/Zip	Phone #

Have you received treatment, medication or advice from a physician in the past for this or a similar condition: ❒ Yes ❒ No
If "Yes", provide the dates, names and address of the physician:

Name	Street Address, City/State/Zip	Phone #
Name	Street Address, City/State/Zip	Phone #

NOTICE

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Alabama Residents Only
WARNING: 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.

Arkansas Residents Only
WARNING: 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.

District of Columbia Residents Only
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 Residents Only
WARNING: Any person who knowingly and with intent to injury, 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.

Louisiana Residents Only
WARNING: 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.

Maryland Residents Only
WARNING: 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 as determined by a court of competent jurisdiction.

Pennsylvania Residents Only
WARNING: 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.

Tennessee Residents Only
WARNING: 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 Residents Only
WARNING: 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 state law.

Washington Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

Name of Claimant (Last, First, Middle)	Date of Birth	Social Security Number

2. Personal Information to be released:
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. I understand my Personal Information will be used by Bankers Fidelity to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Bankers Fidelity to release my Personal Information as follows:
   - other persons or organizations performing business, legal or insurance support services in connection with my claim(s);
     or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan;
     or
   - to my employer for use in discussions with Bankers Fidlity regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work;
     or
   - as otherwise required or permitted by law or as I further authorize

4. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

5. I understand that I may revoke this Authorization at any time by providing a written request to Bankers Fidelity at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Bankers Fidelity receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

Name(s) used for records (if different than the name above) _____

Signature of Claimant _____

Date _____

If Applicable

I am the Legal Representative of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person. If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS.

ATLANTIC AMERICAN
Employee Benefits

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO MY EMPLOYER

I, the undersigned Insured, authorize Atlantic American Employee Benefits to disclose health information about me to my employer and to my employer's broker. I understand that this information may only be used by my employer and its broker to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use, only if they are in direct relation to the claim being audited or adjudicated.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may be significantly delayed or even denied.

This authorization will remain in effect for 24 consecutive months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Claims Department
Atlantic American Employee Benefits
PO Box 105652
Atlanta, GA 30348
Or
Fax (404) 926-4036
Or
Email claims@atlam.com

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Print Name and Address _____

Signature _____ Date _____

Or

If Applicable: I am the Legal Representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person. If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted. Failure to do so may result in a delay in the processing of the claim for benefits.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

Date _____

RETAIN A SIGNED COPY FOR YOUR RECORDS

ATLANTIC AMERICAN
Employee Benefits

Mail To: **Atlantic American Employee Benefits**
PO Box 105652, Atlanta, GA 30348-5652
Toll Free Claim Number: (866) 458-7499
aaemployeebenefits.com

EMPLOYER'S STATEMENT

(Answer all questions to avoid any delays)

TO BE COMPLETED BY EMPLOYER

Company Information

Company Name			
Address	City	State	Zip
Phone #	Email Address		

Employee Information

Employee Name	Phone #		
Address	City	State	Zip
Employee's Job title	Employees Date of Hire	Hrs/per week	
Gross Weekly Earnings / Was disability on the job? ❒ Yes ❒ No	Date of Disability	Date covered under STD plan	
Has employee returned to work? ❒ Yes ❒ No	If "yes", date returned to work. If "no", list expected return to work date.		
Total Disability: What date was the employee totally disabled?	Partial Disability: What date did the employee perform only partial duties?		

Printed name and title of representative completing this form

Signature of representative completing this form

Date

*Please notify Bankers Fidelity if the employee returns to work after the submission of this form.

(Answer all questions in order to avoid delays)

ATTENDING PHYSICIAN STATEMENT

Physician Information

Patient Name	Patient DOB

1. Diagnosis(es) _____

_____

ICD-10 codes _____

2. How did conditions originate? _____

_____

_____

Date Symptoms First Appeared	Initial Date of Treatment	Last Date of Treatment	Next Date of Treatment

Is disability due to:	Is disability work related?	Has patient ever had same or similar condition?
❒ Accident/Injury ❒ Sickness	❒ Yes ❒ No	❒ Yes ❒ No

3. If applicable, list the surgical codes/procedures – describe fully and provide dates, if any. _____

_____

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

Actual Date of Delivery	Actual Type of Delivery
	❒ Natural ❒ Cesarian

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

Was the patient treated in an emergency room?	❒ Yes ❒ No	Date Treated	Name of Hospital
Was the patient hospital confined?	❒ Yes ❒ No	Date(s) Confined	Name of Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center?	❒ Yes ❒ No	Date of Surgery	
Did another physician treat or will be treating the patient?	❒ Yes ❒ No	Date Treated	Name of Physician

1. What functions of the person's own/usual occupation is the person unable to perform? _____

_____

2. What functional restrictions have been placed on this person? _____

_____

How long was or will patient be continuously **totally disabled** (unable to return to work)? From _____ To _____

How long was or will the patient be **partially disabled**? From _____ To _____

Physician Name (Print)	Physician Signature	Date

Physician Address (Street, City/Town, State)	Telephone Number