Community Physical Therapy

Reliance Standard

How to Report/File a Disability Claim

Instructions & Claim Form Attached

Please note revisions on page 3:

- *Premium Payment Responsibilities*
- *Termination of Benefits*

Reliance Standard
How to Report/File a Disability Claim

In order for you to receive short term disability benefit payments while you are out due to non-work related injuries or illnesses, you must complete the Reliance Standard Short Term Disability Claim Packet. There are a few steps that must be followed to avoid any delay in receiving your benefits.

- *You must first meet the eligibility requirements, you must have a doctors note stating that you are not able to work for a period of time.*
- *There is an elimination period as well, which is dependent on whether you are required to be off work due to and injury or illness (maternity falls under the "illness" category).*
- *Effective January 1, 2016 STD claims have a maximum benefit of 13 weeks (3 months).*

When do I report a claim?

- *Obtain physician's care immediately.*
- *Contact the CPT office on or before your first day out of work. Tell them when and how long you expect to be absent.*
- *If you expect to be out for more than 7 consecutive days (this includes weekends), obtain a disability claim from the CPT website http://cptrehab.com/benefits.htm or directly from www.reliancestandard.com. Click on Customer Care, Download Forms, then select State of Wisconsin (Reliance is a Wisconsin company). The claim form will be entitled "Short Term Disability Claim Form".*

What information do I need to provide?

- *You will need to complete part II and sign the Authorization for Use in Obtaining Information page. (effective in 2017, Reliance now offers a Direct Deposit option for your disability payments).*
- *CPT will complete Part I*
- *Your physician is responsible for completing part III.*

How can the claim be submitted?

- *CPT will file your claim for you. Please complete the employee sections and have your physician complete part III, return the completed sections to the CPT business office and we will submit it fully completed directly to Reliance on your behalf. Please see last page for contact information.*

What happens next?

- *Your claim will be sent to the Central intake unit at Reliance, and will be assigned to the benefit specialist within 24 business hours.*
- *Once the benefit specialist reviews the claim, an acknowledgement letter (or phone call if applicable) will be sent to the employee. CPT will receive a copy of the letter. It will outline any missing information, if applicable.*
- *Once the benefit specialist has a complete claim form, a decision will be made on the claim within 3 business days.*

What happens if my claim is approved?

- *If your claim is approved, Reliance Standard will send you an approval letter that provides an explanation of your benefits. CPT will receive a copy of this letter.*
- *If you have a standard maternity claim, you will receive a lump sum check for the duration of your claim. All other disabilities, you will receive a weekly disability check. A copy of your check(s) will be sent to CPT as well.*

What happens if my claim is denied?

- *If your claim is denied, Reliance will send you a letter that explains why. The letter will also tell you how you can appeal the decision. CPT will also receive a copy of this letter.*

What if I can't return to work when my disability benefits end?

- *Call your Reliance claims examiner to talk about the situation. Your claims examiner will explain your options.*
- *Let CPT know your progress.*

Who should I contact if I have a question about my claim?

- *Call the Reliance Customer Care Center toll free at 800.351.7500, Option #2, between the hours of 7:00am & 6:00pm Central Standard Time.*
- *Go to www.reliance standard.com. Click on Customer Care, Self Services Tools, Claims. You will need your date of birth and the last 4 digits of your Social Security Number to review basic information such as decision of claim, last check issued and amount of last check.*

Insurance Premium Payment Responsibilities

- *Please be aware that while you are out on STD, you are responsible for any premiums for insurance plans you are enrolled in with CPT. You as the employee, will be responsible for sending CPT a check(s) directly for premiums owed.*
- *In order to keep in compliance with the Affordable Care Act, employees MUST make payments at least monthly, and stay current with their premiums.*
- *Effective with the 2015 plan year, failure to submit timely payments for premiums owed will result in termination of benefits.*
- *In the event the employee fails to make any required monthly contributions when due, benefits shall automatically terminate at the end of the period for which the last contribution was to be made.*

Termination of Benefits.

- *In the event an employee is absent on account of Illness or Injury, employment shall be deemed to continue for the purpose of benefits hereunder until the earlier of: (i) the date contributions received from the Employer and Employee's portion for such employee's benefits are discontinued; or (ii) a period of [Six (6) months]; or*
- *The benefits of an employee who is temporarily laid-off or granted leave of absence may be continued, but not beyond the end of the leave of absence or lay-off. The leave of absence or lay-off may not exceed [three (3) months].*

The instructions provided by Reliance Standard state that the packet should be sent to Reliance. <u>However, we ask that you send the completed employee and physician sections back to the CPT office, so we can make sure it is completed in its entirety, we will then complete the Employer's sections and then send it on to Reliance for you. Please DO NOT forward the Employee or the Physician statements directly to Reliance.</u>

Please review your information and return to the CPT office for filing. You may return your forms via fax or via email to either Cari or Terrie in the business office.

CPT Business Office Fax#
630-238-5698

Cari Jurkovic
cari.scolaro@cptrehab.com

Terrie Knebelsberger
terrie.knebelsberger@cptrehab.com

Revised 7.2017

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Short-Term Disability Benefits
Initial Statement of Claim

HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

Employer: 1) Complete and sign Part I answering all questions;
2) Attach job description; and
3) Attach proof of earnings as defined by applicable policy (example: payroll records, W-2, K1, 1099, etc.)

Insured: 1) Complete and sign Part II answering all questions; and
2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form, and
3) Have the attending physician complete and sign the ATTENDING PHYSICIAN STATEMENT. **IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.**

Please fax completed claim forms and attachments to 267-256-3519, email to claimsintake@rsli.com or mail to Reliance Standard Life, P.O. Box 7749, Philadelphia, PA 19101-7749

PART I — FOR EMPLOYER TO COMPLETE

Name of Insured (Last, First, Middle Initial)	Date of Birth	Social Security No.	Policy No.

Job Title	Insurance Class	Hire Date	Date Enrollment Card Signed	Effective Date of Insurance

Date Laid Off (If Applicable)	Date Retired (If Applicable)	Weekly Earnings ☐ Weekly ☐ Bi-weekly	Date Last Worked	Numbers of Hours Worked 2 Weeks Preceding the Last Day Worked	Date Returned to Work

Work schedule at time of disability ___ day/week ___ hrs./day

How is Claimant Paid? ☐ Hourly ☐ Salaried ☐ Salary & Bonus ☐ Salary & Commission ☐ Commission Only ☐ Other:

Did the employee receive sick pay after ceasing work? ☐ Yes ☐ No	Date Began	Dated Ended	Reason For Stopping Work

Was sick pay exhausted? ☐ Yes ☐ No
Date exhausted?

If they did not exhaust their sick pay, provide number of remaining sick days or hours

Did the employee receive salary continuation? ☐ Yes ☐ No
Date Began Date Ended

Work State

Is disability work related? ☐ No ☐ Yes
If "Yes," Explain

Brief Description of Duties

Percentage of premium paid by: Claimant _____% Employer _____% If claimant pays any portion of the premium, please indicate whether the claimant's portion of the premium is paid with: ☐ Pre-tax dollars ☐ Post-tax dollars

Is there any reason why FICA taxes should not be withheld from claimant's benefits? ☐ Yes ☐ No If yes, please explain:

Employer Name & Address	Employer's Telephone Number Ext.

Authorized Signature Date	Fax Number	Email Address

PART II — FOR INSURED TO COMPLETE

Home Address (Street, City, State, Zip)	Gender ☐ Male ☐ Female	Dominant Hand ☐ Right ☐ Left Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing Address if different than Home Address (Street, City, State Zip)	Do you wish to receive communications by Email or Mail ☐ Email ☐ Mail	Email Address

Is this Claim Based on an accident? ☐ Yes ☐ No	Did injury occur at work? If "Yes," for whom were you working? ☐ Yes ☐ No	Date you were first unable to work because of this disability

RELIANCE STANDARD
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Short-Term Disability Benefits
Initial Statement of Claim

Date of Accident (if any)	Time ☐ AM ☐ PM	How and where did accident happen?

Name and Address of Attending Physician	Date you returned to work

Are you now receiving Unemployment Compensation benefits? ☐ Yes ☐ No

Are you now receiving or eligible to receive as a result of this disability:
Social Security ☐ Yes ☐ No
Worker's Compensation ☐ Yes ☐ No
State Disability ☐ Yes ☐ No
No Fault Disability ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No

If "Yes" give name and address of insurer, amount of income, date benefits began and ended.

We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:

Federal Tax to be Withheld _____ ($20.00 Minimum per week, whole dollars only)
State Tax to be Withheld _____ ($ 2.00 Minimum per week, whole dollars only)

I authorize RSL to send my disability payments to the Bank designated below for electronic deposit in my Account. I understand that I may terminate this arrangement at any time by writing to the RSL address above.

☐ Yes Set-up Direct Deposit

Bank/Financial Institution Information

Name of Bank (Print)		
Address of Bank		
City,	State	Zip

Choose Type of Account

☐ Checking ☐ Savings

Bank Transit/Routing Number (9 Digits)
Personal Account Number
Or Attach a Voided Check imprinted with your name.

Any person who knowingly and with intent to injure Reliance Standard Life Insurance Company files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.

Insured's Signature	Date	Telephone Number ( )	E-Mail Address

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

P.O. Box 7749
Philadelphia, PA 19101-7749

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S DATE OF BIRTH: _____
POLICYHOLDER: _____

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, pharmacy benefit managers, employers, group policyholders, contract holders, governmental agencies (including but not limited to the Internal Revenue Service and the Social Security Administration), private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Reliance Standard Life Insurance Company and/or its authorized administrators including but not limited to Matrix Absence Management, with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary, tax and/or benefit-related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of Reliance Standard Life Insurance Company's privacy policy is available at www.rsli.com or upon request.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address above. A reproduction of this Authorization shall be considered as valid as the original.

_____ _____
Date Insured's Signature

(If the Insured is unable to sign, an authorized person may sign.)

_____ _____
Date Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:

IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.

PART III ATTENDING PHYSICIAN'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)

Patient's Name

Diagnosis and Concurrent Conditions (including ICD-9 or ICD-10 codes)

Surgical or Obstetrical Procedure

Current Medications

Frequency of Treatment ☐ Weekly ☐ Other ☐ Monthly

Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No

Has patient ever had same or similar symptoms? ☐ Yes ☐ No If Yes, when

Date symptoms first appeared or accident happened

Date patient first consulted you for this condition

Is patient still under your care for this condition? ☐ Yes ☐ No

If condition is due to pregnancy, give LMP and expected date of delivery. LMP _____ Expected Date of delivery _____

If patient hospitalized, give name of hospital Admission Date _____ Discharge Date _____

Is patient able to perform his/her job? ☐ Yes ☐ No

Date patient was continuously unable to work From _____ To _____

Estimate date patient should be able to return to work.

Patient will be partially disabled From: To:

Physical Impairment

☐ 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 function capacity; incapable of clerical or administrative (sedentary*) activity .....(60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity .....(75-100%)
☐ Remarks
*As defined in the Federal Dictionary of Occupational Titles

Psychiatric Impairment -Complete only 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 only limited interpersonal relations *(slight limitations)*.
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only 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 psychological, physiological, personal, and social adjustments *(severe limitations)*.
☐ Remarks

Please define stress as it applies to this patient.
What stress and problems in interpersonal relations has patient had on the job?
Do you believe a legal guardian or conservator should be appointed for this problem? ☐ Yes ☐ No
Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

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Physician's Name, Address, ZIP (Please Print or Type)

Telephone Number ( ) Fax Number ( ) Specialty

Physician's Signature Date Degree Physician's Tax ID No.