UMR
PO BOX 8015 • WAUSAU WI 54402-8015
Disability Income Claim Form

INSTRUCTIONS to the EMPLOYEE

- Complete and Sign the EMPLOYEE section of the form (below) and the HIPAA authorization (page 2).
- Have your doctor complete the PHYSICIAN section of this form (on page 3).
- Give the completed EMPLOYEE and PHYSICIAN forms to the Ancira Team Services office. The Team Services office will complete the remaining verification and submit your claim on your behalf. You will be mailed a final copy for your records.
- Filing a claim containing false, misleading, or deceptive statements is considered insurance FRAUD. Perpetrating fraud may result in dismissal from employment, disenrollment or denial of benefits and may subject the individual to civil or criminal penalties your employer has no control over.

PART A: EMPLOYEE SECTION

All blanks must be comlpeted. Failure to complete this form entirely may cause delays. This form is for Disability Income Benefits only. Benefits are based upon your average income and the established premium collected through your payroll. Benefits are not taxable and will not exceed 60% of your average income. If you over-insured your income, you will be eligible to receive a refund of overpaid premiums for the preceding 12-month period. If approved for benefits, payments are dependent upon your doctor's certification of "disability" and will be mailed to your home mailing address. Your eligibility waiting period for benefits is 7 days.

A. Employee's name (Last) ____________ (First) ____________ (M.I.) ____ Date of Birth ____________

B. Address (Street) ______________________________ PO Box ____________

(City) ____________ (State) ______ (Zip Code) ____________

Home Phone # (______) ____________

C. Date and reason for applying for Disability ______________________________

D. Injury or accident happened? ☐ at home ☐ place of employment ☐ other-explain ____________

E. If injury arose out of or in the course of your job duties,

when was this reported to your employer? ____________________

F. Date entered hospital ____________ Date discharged ____________

NOTICE: If you are currently obligated under Child Support, Federal Tax Lien, or similar, it is your personal duty during your absence to continue making these payments DIRECTLY TO THE AUTHORITY (for example, the Office of the Attorney General). UMR and your Payroll office are unable to do so.

____
Employee Signature

HIPAA AUTHORIZATION

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure.

2. In addition to my Employer, the following person or class of persons may receive disclosure of protected health information about me:

   His/her/its name is: UMR

   His/her/its address is: PO Box 8015, Wausau, WI 54402-8015

3. The specific information that should be disclosed is:

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying UMR in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires 1 year from the date of the individual's signature below.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

______________________________	______________________________	______________________________
Signature of Individual (the person about whom the information relates)	Date of Individual's Signature	Date of Birth or Social Security No.

OR, if applicable

______________________________	______________________________	______________________________
Signature of Guardian Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Guardian's/Personal Representative's Authority to Act for the individual

PART B ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: ______________________ Social Security Number: ______________

1. **Diagnosis** ______________________ **(ICD-9 Code)(s)** ______________

   Hospitalization / dates ____________ Surgery type / date ______________
   (CPT code)(S): ______________
   Where: Office In Patient Out Patient/23 hr

2. **Disability Onset**

   First day unable to work due to disability ____________ Anticipated return to work ____________

   Is the condition or injury a result of a work related accident? ☐ Yes ☐ No If pregnancy, (EDC) date ________

   Is your patient able to perform the duties of his/her job? ☐ Yes ☐ No
   If not, what specific restrictions and limitations does your patient have? ______________

   ____

3. **Objective clinical findings** (x-ray, MRI, CT, labs, etc.) ______________

   ____

   Results and dates: ______________________________

4. **Subjective findings** ______________________________

   ____

5. **Treatment follow up**

   Date of first visit ___ / ___ / ___ Date of most recent visit ___ / ___ / ___ Date of next visit ___ / ___ / ___

6. **Treatment Plan** Specific treatment, frequency and duration (therapies, medications, etc.)

   ____

   ____

7. **Supportive Service - Other treating providers**

   Name & Address: ______________________ Telephone # (_____) ____________

   Name & Address: ______________________ Telephone # (_____) ____________

8. **Remarks:** We are interested in any information that would be helpful to your patient for evaluation of this claim.

   ____

   ____

   ____

Name (MD)____________ Specialty ____________ Telephone # ____________ Fax # ____________

Street Address ______________________ City ____________ State ______ Zip ______

Signature of MD completing form ______________________ Date ____________

Physician Tax ID ____________________

Name of individual completing form, if other than MD ____________________ Title ____________

FORM IS INVALID IF NOT SIGNED BY THE PHYSICIAN AND DATED.

See next page

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Fax #715-841-7766
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PART C TO BE COMPLETED BY THE EMPLOYER

A.

Plan No.	Date of Hire	Effective Date of Coverage	Monthly Disability Benefits	Percentage of Employee Contribution
7670-04-410069				

B. Name of employee ________________ Sex ________

C. Social Security Number ________________ State employee lives in ________________

D. Has the employee made claim for, or is he entitled to Worker's Compensation Benefits? ☐ Yes ☐ No

E. Employee's occupation ________________ Basic Weekly Earnings ________

F. Date employee last worked ________________ ☐ AM ☐ PM How many hours worked ________

G. Prior to this disability was the employee ☐ Laid off ☐ On leave ☐ On Vacation ☐ Discharged

H. Date returned to work ________________ ☐ AM ☐ PM

I. Indicate any vacation (or similar compensation) scheduled for payment during this initial DISABILITY REPORTING PERIOD:

____

Dates that will be paid: ________________ ☐ Vacation ☐ Other ________________

Amount: $ ________________ This is an ☐ Estimate ☐ Actual

____
(Authorized representative) Phone # (Date signed)