INCOME REPLACEMENT DISABILITY CLAIM FORM

INSTRUCTIONS to the EMPLOYEE

- Complete the EMPLOYEE section of this form (below).
- Have your doctor complete the PHYSICIAN section of your claim form (next page).
- A claim containing false, misleading, or deceptive statements or failure to revise your claim when a disability and/or partial disability condition no longer exists as defined under the Plan definitions 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 completed. 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. For details concerning this benefit, contact Caprock.

Your Name: ____ Birthdate: ____________
First MI Last mm/dd/yyyy

Home Mailing Address: ____
#/Street/or P.O. Box City State Zip Code

Home Phone #(_______)__________________ Cell or Alternate #(_______)__________________ Name of Employer: ______________________

This is a [ ]Short Term > 8-day to 180-day [ ]Extended Term > 181 day – 24 mo. Claim

Explain the DISABILITY/what job duties does your injury or illness prevent you from performing?

____

Your disability is due to: (check only one)

[ ] Serious Prolonged Illness (longer than 7 days)
[ ] Accident at Home or on personal time
[ ] Accident at work (explain) ______________________________
[ ] Post-Partum or Other (explain) ______________________________

Date you first knew this would result in "disability"? ______________

Note any claim filed elsewhere to any other insurance carrier, Social Security, or otherwise: **[If "N/A", initial here:** ________No Other Claim Filed**]**

____

List all medical and healthcare providers you have utilized with respect to this reported disability & provide dates of service:

If you will be/have been hospitalized, provide the following information: **[If "N/A", initial here:** ________No Hospital admission is involved**]**

Hospital/Outpatient Facility Name: ______________________________ Ph#______________

Admission Date: ______________ Release Date: ______________ [ ]Actual [ ]Anticipated

PATIENT's/INSURED's AUTHORIZATION and RELEASE

I hereby authorize use or disclosure of protected health information BY MY HEALTHCARE PROVIDERS to representatives of my employer and Caprock Health Group PO Box 15050 Amarillo, TX 79105 for the purposes of evaluating my claim and verifying information related to my claim (as specified above) and hereby **RELEASE, ACQUIT, AND FOREVER DISCHARGE FROM LIABILITY** all parties engaging in exercising, accessing, evaluating, and/or responding to my claim for benefits. I likewise authorize healthcare provider/s to engage in discussion with the employer and/or Caprock to determine if plan definitions are/have been met, including as related to my job duties. The plan document governs the benefit; a current copy of which is available to me either by contacting Caprock to request one and/or at Ancira.ORG. It is the sole responsibility of the insured to (1) seek/apply for a benefit and (2) inform myself of the details of my benefits including timelines and/or claim obligations/restrictions benefits are subject to. I understand benefits may be terminated under any terms of the Plan Document. Any disputes made by me or my dependents/heirs related to benefits are subject to the plan documents as well as any dispute resolution agreements. Medical provider/s to whom this authorization is submitted may not condition treatment of me on this authorization. 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, in which case it is then no longer protected by federal privacy regulations. I may revoke only my HIPAA authorization only by notifying each party in writing. However, I understand that any action already taken cannot be reversed, and my revocation will not apply to those actions. This authorization expires 1 year from the date of my signature below or two years following the conclusion of my claim, whichever comes last. THIS FORM MUST BE FULLY COMPLETED BY THE INSURED (OR IF MEDICALLY INCAPABLE, THE INSURED'S LEGAL REPRESENTATIVE) BEFORE IT IS SIGNED. THIS AND THE PHYSICIAN CLAIM FORM AND ANY REQUESTED MEDICAL RECORDS MUST BE SENT DIRECTLY TO Caprock @ PO Box 15050 Amarillo, TX 79105. If Employee is medically incapable of signing, signature of insured's Personal Representative shall be binding as if signed by Employee.

☐Insured's -or☐Personal Representative's Signature:______________________________ Date: ______________

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PART B: PHYSICIAN'S SECTION **Thank you in advance for your assistance with the following information.**

Patient's Name: ____ Social Security #: _______________________________

Patient's Job Title: ____ Date of Birth: ________________________

Diagnosis: _______________________ ICD-10 CODE(s): ____

Hospitalization Dates: ____________________________________ or [ ]N/A

Surgery Type: ____ Date: ______________________

CPT Code(s): ____
Specify In-Office, In-Patient, Out-Patient/23hr

Disability Onset

Most recent FIRST DAY unable to work due to disability: __________________________

Anticipated release date: ______________________ expected [ ]with [ ]without restrictions

Is the condition relative to pregnancy, (EDC) date? _________________ Note: If normal pregnancy/delivery without disability, skip to signature section.

What specific restrictions and limitations does your patient have? [Note: A copy of the Job's Essential Functions is available by calling 210-558-5005]

Objective Clinical Findings (x-ray, MRI, CT, labs, etc.):

Results & Dates:

Subjective findings:

Treatment Plan and Follow-up

Specific treatment/frequency/duration (therapies, medications, etc.)

Date of First visit: | Date of most Recent visit: | Expected Follow-Up Frequency:

Supportive Services – Other treating/referred providers

Name & Specialty: ____ Ph# (_______)____________________

Name & Specialty: ____ Ph# (_______)____________________

Remarks (Please explain incapacity, limitations, prognosis, therapies, etc. you feel will help us understand and evaluate this disability correctly.)

(Please print legibly)

Physician's Name: | Specialty:

Physician Tax ID# | Ph#( ) | Fax#

Street Address: | City: | State: | Zip:

Name of Person Completing this form: | Physician's Signature: | Date:

THIS COMPLETED PAGE CAN BE FAXED DIRECTLY BY PHYSICIAN'S OFFICE TO SECURE FAX#: 210-699-0575