| TIME-SENSITIVE DOCUMENT | Please complete **ALL** forms and submit to:<br>**Fax:** 603.415.3096 or **Email:** stdclaims@healthtrustnh.org<br>For questions, please call 1.800.527.5001 |
|---|---|

HealthTrust

# DISABILITY INCOME BENEFITS
# Claim and Disability Status Form

## EMPLOYEE STATEMENT

| Name | | Date of Birth | Gender<br>☐ Male ☐ Female |
|---|---|---|---|
| Mailing Address | City | State | ZIP |
| Social Security Number | Occupation | Home/Cell Phone | |
| Email | | | |

1. Date last worked _____ Date you returned or expect to return to work _____

2. When did the illness or accident/injury occur? _____ Please provide a description of the illness or how and where the accident/injury began. _____

3. Did you file any other claim in addition to this STD claim? ☐ Yes ☐ No
   If yes, with what entity did you file the claim (worker's compensation, automobile insurance, other third party)?_____
   Is a third party responsible? ☐ Yes ☐ No If yes, claim # _____

4. Are you or will you be receiving wage-replacement benefits from any other insurer? ☐ Yes ☐ No
   If yes, name of insurer: _____ Contact person and phone _____

5. Are you represented by an attorney with respect to this claim? ☐ Yes ☐ No
   If yes, name of attorney: _____ Phone _____

6. Is this condition related to work? ☐ Yes ☐ No
   Have you filed a Workers' Compensation claim? ☐ Yes ☐ No Status of your claim: ☐ Approved ☐ Pending ☐ Denied
   If your Workers' Compensation claim was denied, has an appeal been filed? ☐ Yes ☐ No
   Name of Workers' Compensation carrier: _____ Contact and phone: _____

7. **List ALL treating physicians:**

Name _____ Phone _____ Name _____ Phone _____

Name _____ Phone _____ Name _____ Phone _____

8. Did you seek treatment at a hospital emergency room? ☐ Yes ☐ No
   If yes, when _____ and where? _____
   Address _____ City _____ State _____ ZIP _____

9. Beneficiary Name _____ Address _____ City _____ State _____ ZIP _____

Employee Signature _____ Date _____



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|---|---|

# DISABILITY INCOME BENEFITS
## Claim and Disability Status Form

Employee Name _____ Date of Birth_____

**EMPLOYER STATEMENT**

1. Date hired _____ Date last worked _____ Date work resumed _____
2. Base Annual Salary $_____ Effective date of salary _____ Class _____
3. Is this claim being filed for ☐ Accidental injury ☐ Illness ☐ Maternity
4. Is this condition work related? ☐ Yes ☐ No If yes, Workers' Comp denial required.
5. Regularly scheduled work week = _____ hours.
6. Any additional information that might be helpful to process this claim. _____

_____

Employer _____

Contact Person _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Signature _____ Title _____ Date _____



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|---|---|

# DISABILITY INCOME BENEFITS
## Agreement Concerning Benefits

| Name of Claimant | | | Date of Disability |
|---|---|---|---|
| Mailing Address | City | State | ZIP |
| Employer | | | |

In consideration of the **[advance]** payment of weekly income benefits made to me by my employer under my employer's Short-Term Disability Plan (the "Plan"), administered by HealthTrust, I represent, acknowledge and agree that:

1. I have not received and am not currently receiving any other benefits or payments for loss of income due to my disability from Workers' Compensation, automobile insurance, individual disability or other insurance, any state or federal disability income or unemployment benefit law or similar law, or any other type or source of wage replacement;

2. My benefits under the Plan will be reduced by any such benefits or payments for loss of income for which I may be eligible while disabled, and that I will not be eligible for any benefits under the Plan for any period that I am eligible to receive benefits from Workers' Compensation;

3. If I receive any such benefits or payments during my disability, regardless of the source or amount, I will immediately notify my employer and HealthTrust of such benefits or payments and will pay back all amounts paid to me by the Plan which exceed the amount actually due to me under the terms of the Plan;

4. To the extent benefits are paid to me pursuant to the terms of the Plan, my employer and HealthTrust will be subrogated and succeed to any recovery or right of recovery I might have against (i) any third party who is responsible for causing my disability, or (ii) any workers' compensation carrier, other insurer or other provider of income replacement benefits which are paid or payable to me due to my period of disability; and

5. I have an obligation to inform my employer and HealthTrust of any such income replacement benefits or payments that may be available and to provide such information and assistance, and execute such documents, as HealthTrust may require to assist in the recovery of such benefits or payments.

I understand that my employer and HealthTrust, in reliance on the above statements and promises, will agree to advance benefit payments to me from the plan.

| | | | |
|---|---|---|---|
| **Witness (Sign)** | **Date** | **Claimant (Sign)** | **Date** |
| **Witness (Print)** | **Date** | **Claimant (Print)** | **Date** |

| TIME-SENSITIVE DOCUMENT | Please complete **ALL** forms and submit to:<br>**Fax:** 603.415.3096 or **Email:** stdclaims@healthtrustnh.org |
|---|---|

# DISABILITY INCOME BENEFITS
## Patient's Authorization to Release Information

**INSTRUCTIONS: 1. Employee must complete, sign and date this release. 2. Employee must provide a copy to physician.**

I authorize my medical care provider(s) to disclose to HealthTrust any information relating to my current medical condition necessary to process my claim for disability income benefits under my employer's Short-Term Disability Plan. With respect to my authorization to release my medical information, I understand and acknowledge that:

- I can revoke this authorization at any time by giving my written revocation to my physician or other medical care provider.
- My healthcare treatment by my physician or other medical care provider will not be affected if I refuse to sign this form.
- I am authorizing disclosure of information protected under federal privacy law and that the information, once disclosed, could be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.
- If I do not revoke it, this authorization will expire 18 months from the date that I sign it.
- I am entitled to receive a signed copy of this authorization and a copy will serve as an original.

I acknowledge that this authorization is subject to the terms set forth above, all of which I have read and understand.

Name of Patient: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____

Patient's Signature _____ Date _____

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|---|---|

HealthTrust

# DISABILITY INCOME BENEFITS
## Physician Statement

PHYSICIAN **MUST** COMPLETE THIS SECTION IN ITS ENTIRETY, **SIGN AND DATE** BELOW.

Patient Name: _____ Date of Birth: _____

1. Is this condition related to employment? ☐ Yes ☐ No

2. Patient's condition is a result of: ☐ Illness ☐ MVA ☐ Injury/Accident ☐ Pregnancy
   Date of Delivery: _____ ☐ C-Section ☐ Natural

3. Primary Diagnosis: _____ ICD-10 Code: _____

4. Date of first treatment: _____ Date of most recent treatment: _____

5. Date Patient has been totally and continually disabled (unable to work):_____

6. Patient will be disabled through: _____ If unable to determine, please give an estimated date.

**Treatment Plan:**

7. Will the patient require surgery? ☐ Yes ☐ No Date of Surgery: _____

8. Describe the patient's current physical and mental limitations during the time of disability.
   _____

9. Planned course of treatment (please include expected duration, additional surgeries, therapy, etc.):
   _____

10. Could the patient be released to work with restrictions? ☐ Yes ☐ No Date: _____ If yes, please list restrictions:
    _____

11. Date the patient can return to work: Light Duty: _____ Part-Time: _____ # of hours per week: _____

12. Date of next follow-up visit: _____

Physician's name *(please print):* _____ Date: _____

Physician's signature: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____



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