PLEASE COMPLETE IN FULL AND RETURN WITHIN 30 DAYS.

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 614.487.9603 • www.uct.org

Disability Income Plan Claim Application

PLEASE PRINT

FOR OFFICE USE ONLY: ☐ DIP ☐ ADHIP ☐ HIP ☐ EMERGICARE ☐ SIP ☐ MAC

CLAIMANT INFORMATION

Policy Number: ____________________

1. Name: ______________________________ (First, MI, Last) Phone: (________) ____________
2. Address: ______________________________ (Street / City / State/Prov. / Postal Code)
3. New Address? ☐ Yes ☐ No Temporary Address? ☐ Yes ☐ No If "Yes," for how long? ________

   Email Address: ______________________________

4. Date of Birth: ____/____/____ (Month/Day/Year) 5. Sex: ☐ Male ☐ Female 6. Height: ________ 7. Weight: ________
8. Occupation: ______________________________ Retired?: ☐ Yes ☐ No
9. Employer's Name: ______________________________ Phone: (________) ____________
10. Employer's Address: ______________________________ (Street / City / State/Prov. / Postal Code)
11. Position Held: ____________________ Description of Duties: ____________________
12. Type of Business (manufacturing, construction, retail, etc.) ____________________

ACCIDENT INFORMATION

13. Date of Accident: ___/___/___ (Month/Day/Year) 14. Time of Accident: ___:___ am/pm 15. Date Physician First Contacted: ___/___/___ (Month/Day/Year)
16. Describe Injuries: ______________________________
17. Describe Accident: ______________________________
18. If accident occurred on job, check here: ☐

DISABILITY

19. If you are NOT claiming disability, please check here: ☐ and attach copies of itemized bills.
    If you ARE claiming disability, please continue.
20. **TOTAL** Disability: From ____/____/____ (Month/Day/Year) am/pm To ____/____/____ (Month/Day/Year) am/pm

    PARTIAL Disability: From ____/____/____ (Month/Day/Year) am/pm To ____/____/____ (Month/Day/Year) am/pm
21. Is disability continuing? ☐ Yes ☐ No
22. What duties are you unable to accomplish? ______________________________

HOSPITALIZATION (PLEAS ATTACH COPIES OF SUMMARY SHEETS FROM ANY AND ALL CONFINEMENTS)

23. Were you confined to a hospital? ☐ Yes ☐ No If "Yes," please indicate the following:
24. Name of Hospital: ______________________________
25. Address: ______________________________ (Street / City / State/Prov. / Postal Code)
26. Dates of Confinement: From ____/____/____ (Month/Day/Year) am/pm To ____/____/____ (Month/Day/Year) am/pm

COMMENTS: ______________________________

____

In Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
In Other States: Any person who knowingly and with intent to defraud any insurance company or other person, files a 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.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to my physical or mental condition and/or treatment and any other non-medical information, to give The Order of United Commercial Travelers of America or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I am not required to sign this authorization form and that UCT will not condition the provision of payment for benefits to me on the signing of this authorization. However, UCT may condition payment of a claim for benefits on my authorization for disclosure of my information held by another person or entity, if such information is necessary to determine payment of a claim.

I agree that this authorization shall be valid for one year from the date shown below.

Release of all treatment records from: ______________________________ to: ______________________________

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the *Notice of Privacy Practices* of UCT. I understand that I may revoke this authorization in writing at anytime, except to the extent that action has already been taken by UCT in reliance on this authorization, by sending a written revocation to UCT, Privacy Officer, 1801 Watermark Drive, Suite 100, Columbus, OH 43215.

Name of Insured: ______________________________ Social Security No.: __________________ Date of Birth: ________

Date: _______/_______/_______ (Month/Day/Year) Signature: **X** ______________________________ (Signature of Claimant or Representative)

If signed by a guardian or a power of attorney, we must have notarized papers verifying this.

ANY COST FOR COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT

ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY YOUR DOCTOR)

1. Patient's Name: ______________________________ 2. Date of Birth: ______/______/______ (Month/Day/Year)
3. Diagnosis: ______________________________
4. Accident?: ☐ Yes ☐ No If "Yes," date of accident: ______/______/______ (Month/Day/Year) First date seen: ______/______/______ (Month/Day/Year)
____
5. Description of Accident: ______________________________
6. Please list all treatment dates: ______________________________
7. Was the patient hospitalized? ☐ Yes ☐ No If "Yes," when? From ___/___/___ (Month/Day/Year) am/pm To ___/___/___ (Month/Day/Year) am/pm
8. Dates of Disability: **TOTAL** Disability: From _____/_____/_____ (Month/Day/Year) am/pm To _____/_____/_____ (Month/Day/Year) am/pm
   PARTIAL Disability: From _____/_____/_____ (Month/Day/Year) am/pm To _____/_____/_____ (Month/Day/Year) am/pm
9. Is disability continuing? ☐ Yes ☐ No If "Yes," please estimate recovery time: _____/_____/_____ (Month/Day/Year)
10. Please list referring physician and their address: ______________________________
____
11. Has claimant ever received treatment for the same or similar condition? ☐ Yes ☐ No If "Yes," please elaborate:
____
12. Charge for office calls: $ ____________________ Charge for X-rays: $ ____________________
13. Physician's Name: ______________________________ 14. Physician's Phone: ____________________
15. Physician's Address: ______________________________ (Street, City, State/Prov., Postal Code)
16. Physician's Signature: **X**: ______________________________ Degree: __________ Date: _____/_____/_____ (Month/Day/Year)

COMMENTS: ______________________________