



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, Columbus, OH 43215
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Disability Income Plan Claim Application PLEASE PRINT

FOR OFFICE USE ONLY: [ ] DIP [ ] ADHIP [ ] HIP [ ] EMERGICARE [ ] SIP [ ] MAC

CLAIMANT INFORMATION

Policy Number: \_\_\_\_\_

- 1. Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_
2. Address: \_\_\_\_\_
3. New Address? [ ] Yes [ ] No Temporary Address? [ ] Yes [ ] No If "Yes," for how long? \_\_\_\_\_
4. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 5. Sex: [ ] Male [ ] Female 6. Height: \_\_\_\_\_ 7. Weight: \_\_\_\_\_
8. Occupation: \_\_\_\_\_ Retired?: [ ] Yes [ ] No
9. Employer's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_
10. Employer's Address: \_\_\_\_\_
11. Position Held: \_\_\_\_\_ Description of Duties: \_\_\_\_\_
12. Type of Business (manufacturing, construction, retail, etc.) \_\_\_\_\_

ACCIDENT INFORMATION

- 13. Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ 14. Time of Accident: \_\_\_\_:\_\_\_\_ am/pm 15. Date Physician First Contacted: \_\_\_\_/\_\_\_\_/\_\_\_\_
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 \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm
PARTIAL Disability: From \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm
21. Is disability continuing? [ ] Yes [ ] No
22. What duties are you unable to accomplish? \_\_\_\_\_

HOSPITALIZATION (PLEASE 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: \_\_\_\_\_
26. Dates of Confinement: From \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To \_\_\_\_/\_\_\_\_/\_\_\_\_ 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: **X** \_\_\_\_\_  
Month/Day/Year (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: \_\_\_\_/\_\_\_\_/\_\_\_\_ First date seen: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month/Day/Year Month/Day/Year

5. Description of Accident: \_\_\_\_\_

6. Please list all treatment dates: \_\_\_\_\_

7. Was the patient hospitalized?  Yes  No If "Yes," when? From \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm  
Month/Day/Year Month/Day/Year

8. Dates of Disability: **TOTAL** Disability: From \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm  
Month/Day/Year Month/Day/Year

**PARTIAL** Disability: From \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm  
Month/Day/Year Month/Day/Year

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:** \_\_\_\_\_