APL Claims Department
P.O. Box 248950
Oklahoma City, OK 73124-8950

Phone: 800-256-8606
Fax: 877-365-9423
www.ampublic.com

Group Disability Claim Filing Instructions

IMPORTANT: All portions of this claim form must be completed ***after*** disability begins to avoid undue delay in processing claimant's request for benefits.

1. Complete "Employee – Initial Disability Claim Form" in full.
2. Have treating physician complete the "Physician – Initial Disability Claim form" and return to you.
3. Have your Employer complete the "Employer – Initial Claim Form" and return to you.
4. Complete the Direct Deposit Authorization Agreement below if you prefer funds to be deposited directly into your checking account.
5. Submit all completed forms to the Claims Department, P.O. Box 248950, Oklahoma City, OK 73124-8950 or you may fax all completed forms to **877-365-9423.**

DIRECT DEPOSIT AUTHORIZATION

IMPORTANT: Funds from direct deposits will ***NOT*** become available to use any earlier than 3-4 business days following the date the benefits are approved and the credit entry is initiated to your account. If you have already filed a Direct Deposit Authorization Agreement, do not complete another, unless your Bank or Credit Union account information has changed.

DIRECT DEPOSIT INSTRUCTIONS:

Complete and sign the form below and attach a voided/cancelled check to AUTHORIZATION AGREEMENT. A deposit slip is ***NOT*** acceptable.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS:

I authorize American Public Life Insurance Company to initiate credit entries to my checking account at the depository named below. This authorization is to remain in full force and effect until the Company has received written notification from me of its termination in such time and in such a manner as to afford the Company and the Depository opportunity to act on my request.

BANK/CREDIT UNION NAME: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

BANK/CREDIT UNION PHONE NUMBER: _____

YOUR SOCIAL SECURITY NUMBER: _____

PRINT NAME: _____ **DATE:** _____

SIGNED: _____

ATTACH VOIDED/CANCELLED CHECK

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EMPLOYER – INITIAL CLAIM FORM

Employee Name:	Social Security Number:
Occupation:	Hire Date:

STATUS OF EMPLOYMENT: Full time: Part Time: Days per week: _____ Hours per day: _____

If employee's status has changed, please check the appropriate box and provide change date below:

Lay Off: Leave of Absence: Terminated: Retired:

PREMIUMS:

Are the employee's disability premium contributions deducted pre-tax _ or post-tax _?

What percentage of the disability premiums do you pay? _____%

Are Social Security taxes withheld from employee's pay check? Yes No

Date that last disability premiums were deducted from payroll: _____Amount deducted: $_____

SALARY AT TIME OF DISABILITY:

Hourly: $_____ Weekly $_____ Monthly: $_____

Annually: $_____ $_____
W-2, previous calendar year Year-to-date, current calendar year

Date last worked? _____

Has employee returned to work: Yes No Return date: _____ Full Time Part Time

Is the employee receiving or eligible to receive any of the following?

	Yes	No	Amount	Wk	Mo	Company Name and Phone Number	Date Benefits Begin	Date Benefits End
Other Group Disability	☐	☐	$	☐	☐			
Salary continuation	☐	☐	$	☐	☐			
Sick Leave PTO/PPT Other (Bonus, etc.)	☐ ☐ ☐	☐ ☐ ☐	$ $ $	☐ ☐ ☐	☐ ☐ ☐			
Retirement/Pension	☐	☐	$	☐	☐			

Is disability the result of work related injury/illness? Yes ☐ No ☐

If yes, has a Workers' Compensation claim been filed? Yes ☐ No ☐

Please provide the name and phone number of Workers' Compensation carrier:

Employer Name:		Office Phone Number:	Fax Phone Number:	
Street Address:	City:		State:	Zip Code:
Form completed by: (please print)			Title:	
Signature:			Date:	

This documents that the above statements are true and complete to the best of my knowledge.

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EMPLOYEE – INITIAL DISABILITY CLAIM FORM

Name:	SS #:	Date of Birth:	Policy/Certificate #:
Complete Mailing Address:	Complete Residence Address:	Telephone Number:	

Do you have dependents under age 18: Yes ☐ No ☐ If yes, please list dependents' names and dates of birth below:

1) Please list medical condition or injury causing disability:	2) If disability is the result of an accident, please explain where, when, and how accident happened:

3) Is your disability the result of your employment? Yes ☐ No ☐ If yes, please submit copy of Workers' Compensation award or denial letter.

4) Please list all dates of medical treatment pertaining to current disability:	5) Have you ever had or been treated for same or similar condition? Yes ☐ No ☐ If yes, please explain:

6) Please list name and phone number of treating physician(s):

7) Date Last Worked: Date Returned to Work:	8) If you *have not* returned to work, what is the anticipated return date? Full Time: _____ Part Time:	9) If your request for benefits is approved, do you want Federal Taxes withheld from each benefit check? Yes ☐ No ☐ (Minimum amount required is $87 per month.) $_____

10) Identify other income sources and amounts of income which you are receiving or may be entitled to receive during this disability:

Social Security – Disability	Yes ☐ No ☐ $_____	V.A. Benefits	Yes ☐ No ☐ $_____
Social Security – Retirement	Yes ☐ No ☐ $_____	Sick Leave or Wage Continuation	Yes ☐ No ☐ $_____
Dependent Social Security	Yes ☐ No ☐ $_____	Retirement (normal, early or disability)	Yes ☐ No ☐ $_____
State Disability	Yes ☐ No ☐ $_____		
Other Group Disability Coverage	Yes ☐ No ☐ $_____		

Include a copy of your award or denial letter from any source that you have received.

WARNING - AL - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof. **AK -** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **AZ -** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. **AR, DC, LA, RI and WV -** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **CA and TX -** For your protection California and Texas law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **CO -** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **DE, ID and OK -** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **FL -** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **IN -** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **KY -** 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. **ME, TN, VA and WA -** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MD -** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **MN -** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NH -** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. **NJ -** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **NM -** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. **OH -** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **PA -** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____	_____	_____
Signature	**Print Insured's/Patient Name**	**Date Signed**

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PHYSICIAN – INITIAL DISABILITY CLAIM FORM

Patient's Name:	Social Security Number:	Date of Birth:

Diagnosis: Please list diagnosis resulting in patient's *temporary* total disability (including complications)

Diagnosis: _____ ICD Code: _____

Diagnosis: ICD Code:

Is disability the direct result of patient's employment? Yes ☐ No ☐

Is disability the result of a pregnancy? Yes ☐ No ☐ If yes, date pregnancy was diagnosed: LMP:

Delivery date (if delivered): Expected delivery date (if not delivered):

History: Was the patient referred to you? Yes ☐ No ☐ Unknown ☐ If yes, please provide name and phone number of referring physician:

Date symptoms first appeared or accident happened:	Date patient first consulted you for this condition:

Are you aware if this patient has ever had the same or similar condition? Yes ☐ No ☐ If yes, please provide explanation including first date of onset:

Treatment: Is patient still under your care? Yes ☐ No ☐ If yes, date of next appointment: _____

List all treatment dates: _____

Please describe treatment plan: _____

If patient is no longer under your care, please provide name and phone number of current physician: Unknown

Has patient been confined to a hospital? Yes ☐ No ☐ Admitted: _____Discharged:_____

Hospital Name: Phone Number:

If surgery is/was necessary, please list procedure(s):

Date scheduled: Date performed:

Prognosis: **Please list date(s) of temporary total disability (unable to work) From: _____Through_____**

If patient is currently totally disabled, please indicate the anticipated length of disability by checking the appropriate box below:

Months: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 or Permanently Disabled or Other _____

Impairment: List functional limitations/restrictions that render your patient *temporarily* totally disabled:

Attending Physician's Name: (please print)	Degree:	Specialty:
Street Address:	City:	State/Zip Code:
Office Phone Number:	Fax Phone Number:	Federal Tax ID Number:
Form completed by:	Title:	
Signature of Physician:	Date:	

Attention Physician: This form documents your verification that the above named individual is totally disabled from their occupation. You will be asked periodically for updates related to the individual's disability and treatment plan.

Clear Form