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

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

# REQUEST FOR CONTINUING DISABILITY BENEFITS - SUPPLEMENTAL

## INSTRUCTIONS TO THE INSURED

1. Complete and sign the "Employee – Continuing Disability Claim Form."
2. Have the physician treating you complete the "Physician – Continuing Disability Claim Form" and have it returned to you.
3. Submit all completed claim forms to the address/fax number above.
4. If you prefer to have benefits directly deposited into your checking account, please contact our office by calling the phone number above.

## EMPLOYEE – CONTINUING DISABILITY CLAIM FORM

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

1. Are you currently working? Yes No

   If yes, when did you return to work? If no, when do you expect to return to work?
2. List your current daily activities:
3. Have any other medical conditions or injuries happened since the last report? Yes No If yes, please explain:
4. Has your employment terminated? Yes No If yes, list the termination date:
5. If your request for Benefits is approved, do you want Federal Taxes withheld from each benefit check? Yes No
   If yes, indicate dollar amount: (Minimum amount required is $87 per month) $

**6. 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**

## PHYSICIAN – CONTINUING 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:

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

Please describe treatment plan for the next 3 – 6 months: _____

If no, please provide discharge date and reason for discharge:_____

Please provide name and phone number of current physician: Unknown

**Dates of Service:** Please provide dates of medical attention since last report:

**Extent of Disability:**

Is patient currently *temporarily* totally disabled? (unable to work) Yes No

If no, please provide return to work date: _____

If yes, please provide *temporary* total disability dates:

Any Occupation: From: _____ Through: _____

Own Occupation: From: _____ Through: _____

Is patient a suitable candidate for a rehabilitation program? Yes No

Is patient partially disabled? Yes No From: _____

Please list restrictions:

**Physical Impairments:** (*As defined in Federal Dictionary of Occupational Titles)

_ Class 1 – No limitation of functional capacity, capable of heavy work. No restrictions. *(0-10%)
Class 2 – Medium manual activity. *(15-30%)
Class 3 – Slight limitation of functional capacity; capable of clerical/administrative sedentary activity. *(35-55%)
Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. *(60-70%)
Class 5 – Severe limitation of functional capacity; incapable of minimum sedentary activity. *(75-100%)

Please list functional limitations/restrictions that render your patient *temporarily* totally disabled:

**Hospital Discharge Information:** Has patient been hospitalized since last report? Yes No

Name of hospital: _____ Admission Date: _____ Discharge Date: _____

| 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. You will be asked periodically for updates related to the individual's disability and treatment plan.*