EPIC | SPECIALTY BENEFITS

Short-term Disability Claim Form

Employee Statement

1. Name | 2. Date of Birth

3. Street Address | 4. Telephone

5. City State Zip | 6. E-mail Address

7. Group Number & Division | 8. Certificate Number and Social Security Number (required for tax purposes)

9. Current job title with your employer | 10. Male Female Height _____ Weight _____

11. Please list all symptoms associated with your claim:

12. Date you ceased work: _____ Have you returned to work? Yes No If yes, date returned: _____ Full-Time Part-Time

If you have returned to work part-time please indicated the number of hours: _____ per day _____ days per week

13. Date first treated for this condition: _____ | 14. Name of physician that provided initial treatment: _____

15. Have you ever had the similar condition in the past? Yes No If yes, give name and address of physician:

16. Please provide the names, addresses and telephone numbers of your family physician and other treating physicians.

17. Please list any other health conditions that may affect your claim:

18. Is this disability injury related? Yes No **If yes, please describe how, when and where the injury occurred.**

19. Did your illness or injury occur as a result of engaging in any activity for pay, profit or gain? Yes No
If yes, please provide the name and address of the employer where the illness or injury occurred.

20. If you claim was approved or denied by the workers compensation carrier, **please provide a copy of the approval or denial letter with your claim.**

21. Are you receiving any income(s)? Yes No

If yes, please provide the gross benefit:

A. Social Security Disability Income: $_____ from _____ through _____

B. Workers Compensation Income: $_____ from _____ through _____

C. Sick Time: $_____ from _____ through _____

D. Vacation Time: $_____ from _____ through _____

E. Other income (including income from other insurance policies): $_____ from _____ through _____

F. If you are receiving any income, please provide the names and addresses, policy number and the date payments began and/or ceased.

FEDERAL INCOME TAX WITHHOLDING – Not Applicable When the Employee Pays 100% of the Premium (Voluntary Plan)

22. If you would like EPIC to withhold Federal Income Tax from your available disability benefit, please complete a **Federal Income Tax Withholding Form.**

Note for Self-funded Plans: If your employer is funding your short-term disability plan, EPIC is required by law to withhold Federal Income

AUTHORIZATION TO DISCLOSE HEALTH-RELATED INFORMATION
(This Authorization complies with the HIPAA Privacy Rule)

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Life"). "Information" may include my entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Life to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Life.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Life. I am aware that my revocation will not be effective until received by EPIC Life and will not be effective regarding the uses and/or disclosures of my Information that EPIC Life has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Life with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Life from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that once Information is disclosed under this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

I certify that the information I have provided on this form is true, complete, and accurate to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss may be subject to imprisonment, fines, denial of insurance, and/or civil damages.

Name of Claimant	Claimant's Date of Birth
Signature of Claimant or Personal Representative*	Date Signed

*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation)

MAIL OR FAX FORM TO:

EPIC Specialty Benefits
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-223-2179

For residents of Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Wisconsin, West Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** EPIC shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

For residents of Pennsylvania: 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 a person to criminal and civil penalties.