Federal Income Tax Withholding Form

Not Applicable to Voluntary Plans

Please complete this form if you would like EPIC to withhold Federal Income Taxes from your benefit payments. EPIC recommends that you discuss this option with your tax advisor to ensure you are making the best decision based on your premium contribution. The minimum amount you may request to withhold is $20 per week.

I am requesting The EPIC Life Insurance Company to withhold $ _____ per week from my available disability benefit payments for my Federal Income Taxes. I understand that my request is valid for the duration of my claim or 7 days after EPIC receives my written request for a change or discontinuance.

_____ _____

Name of Claimant *Claimant's Date of Birth*

_____ _____

Signature of Claimant or Personal Representative *Date Signed*

MAIL OR FAX FORM TO:

EPIC Specialty Benefits
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
claims@epiclife.com
Fax: 608-327-6307

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)

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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.

EPIC SPECIALTY BENEFITS

Short-term Disability Claim Form

Employer Statement

1. Employee Name

2. Employee Certificate Number

3. Policy Number

4. Date of Hire

5. What was the last day worked and number of hours worked that day?

6. A. Was sick time paid? Yes No If yes, please provide date(s) paid. _____ through _____

B. Was vacation time paid? Yes No If yes, please provide date(s) paid. _____ through _____

C. Was salary continuation paid? Yes No If yes, please provide date(s) paid. _____ through _____

7. Did the sickness or injury arise out of or in the course of employment? Yes No

If yes, has a workers compensation claim been filed? Yes No If yes, please provide date(s) paid.
If yes and the claim was denied by your workers compensation carrier, **provide a copy of the DENIAL letter with this claim.**
If no, please explain

8. Is the employee back to work? Yes No Full-Time Part-Time

If yes, please provide the return to work date and copy of physician's return to work notice.

9. If employee is partially disabled, are you able to make reasonable accommodations? Yes No

(example: an employee's job requires daily lifting and carrying of objects in excess of 25 lbs. If the physician releases the employee to return to work with a restriction of lifting and carrying a maximum of 10 lbs. for 3 weeks, can you reasonably accommodate this restriction?)

Note: If you have partial disability coverage and the employee returned to work part-time, you must include the number of hours and days worked as well as the earned wages during the week. This information MUST be sent, faxed, or emailed to EPIC at the end of each week.

10. Employee's average weekly wage?

11. Employee's average hours per week?

12. Was the employee insured under your prior STD policy? Yes No

If yes, what was the employee's effective date of the prior policy?

13. Job Title

(**IMPORTANT: PLEASE ATTACH JOB DESCRIPTION)**

14. Prior to disability, did you consider your employee able to perform (complete based upon employee's job prior to disability)?

Sedentary Work: Lift 10 lbs. maximum and occasionally carry small objects

Light Work: Lift 20 lbs. maximum and frequently lift/carry up to 10 lbs.

Medium Work: Lift 50 lbs. maximum and frequently lift/carry up to 25 lbs.

Heavy Work: Lift 100 lbs. maximum and frequently lift/carry up to 50 lbs.

Very Heavy Work: Lift in excess of 100 lbs. and frequently lift/carry 50 lbs.

15. Did the employee perform the following tasks (prior to disability)?

	Never	Occasionally (1-33%)	Frequently (34-56%)	Continuously (57-100%)
Push/pull when seated				
Push/pull when standing				
Bend				
Squat				
Crawl				
Climb				
Reach above shoulder level				

16. Assuming an 8-hour workday with two fifteen-minute breaks and ½-hour meal break;
I expect this employee to be able to:
(check the number of hours for each activity)

Sit	1	2	3	4	5	6	7	8	Continuously	With Rest
Stand	1	2	3	4	5	6	7	8	Continuously	With Rest
Walk	1	2	3	4	5	6	7	8	Continuously	With Rest
Alternately sit/stand	1	2	3	4	5	6	7	8	Continuously	With Rest

Comments: _____

FICA TAX WITHHOLDING INFORMATION

17. Indicate employee's Social Security Identification Number as shown on your employment records:

18. Do you contribute 100% of the premium for the employee's short-term disability coverage? Yes No

If no, what percentage of the premium for such coverage is contributed by you _____%; by the employee _____%

19. If the employee contributes to the premium; is the contribution: Pre-Tax Post-Tax

20. Employer Group Name

21. Name and Title of Individual Completing this Form

22. Employer Address City State Zip

23. Employer Telephone | 24. Employer Fax Number

25. Employer E-mail Address

26. Signature of Authorized Representative | Date

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EPIC SPECIALTY BENEFITS

Short-Term Disability Claim Form

Attending Physician Statement

1. Patient's Name	2. Identification Number	3. Date of Birth
4. Date you first treated this patient	5. Date of most recent treatment	6. Date of next visit
7. Date sickness or injury began	8. Patient's Height _____ Patient's Weight _____	
9. Diagnosis code (ICD-9 code)	10. Description	

11. Medication(s) prescribed

12. Is the condition primarily related to: (check all that apply) Employment MVA Illness Pregnancy Mental Disorder Injury Alcohol or Drug Dependence

13. If patient was hospitalized, please provide admit and discharge dates: Admit _____ Discharge _____

14. Has surgery been done? Yes No
If yes, date of surgery _____ CPT Code or Description of Procedure _____

15. Is this illness or injury intentionally self-inflicted or attempted suicide? Yes No
If yes, please provide details:

16. Is this illness or injury resulting from weight control or treatment of obesity not caused by an organic condition? Yes No
If yes, please describe your objective findings:

17. To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment, advice or recommendations for this condition prior to this disability onset? Yes No
If yes, please provide the name, address and telephone number of the referring physician.

18. Physical restrictions/limitations (as defined in the 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 light work. (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%)

What are the patient's physical restrictions/limitations?

19. Mental impairments (if applicable)

Class 1-Patient is able to function under stress and engage in interpersonal relations (no limitations).
Class 2-Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
Class 3-Patient is able to engage in only limited stress situations or engage in limited interpersonal relations (moderate limitations).
Class 4-Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
Class 5-Patient has significant loss of physiological, psychological, personal and social adjustment (severe limitations).

What are the patient's mental impairments?

For TOTAL DISABILITY, PARTIAL DISABILITY, or MATERNITY claims, please complete the appropriate section on the reverse side of this form.

TOTAL DISABILITY

20. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

21. Date you advised your patient to stop working?

22. Are there any additional medical conditions or complications affecting your patient's recovery? Yes No
If yes, please explain.

23. What is the patient's expected return to work date?

24. Is the patient a candidate for partial disability? Yes No If yes, refer to PARTIAL DISABILITY section below.

PARTIAL DISABILITY

25. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

26. Date you advised your patient to stop working?

27. Date you advised your patient to return to work part-time?

28. What is the number of days or hours the patient can resume part-time work?

29. What is the patient's expected return to work date on a full-time basis?

MATERNITY

30. Is this disability due to pregnancy? Yes No

31. Date of Last Menstrual Period:

32. If disability is prior to delivery, what are the complicating factors (be specific) and expected date of delivery?

33. Date you advised your patient to stop working?

34. What was the patient's expected date of delivery: _____ Actual date of delivery: _____

35. Type of delivery? Vaginal C-section

36. What is the patient's expected return to work date?

PHYSICIAN INFORMATION

Physician's Signature

Date

Physician Name (Please Print)

Physician Address City State Zip

Physician Telephone Number

Physician Fax Number

Medical Records Department Fax Number

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