

P.O. Box 1535  
 Dubuque, IA 52004-1535  
 877-676-5789  
 563-557-3360 (Claims Fax)  
 CompanionClaims@CompanionLife.net

**See Last Pages Companion Life Form 95734 for Fraud Notices**

To prevent delays, complete claim in its entirety. Incomplete claims will be returned.

**PART I – INSURED INFORMATION**

1. <b>Insured's Name</b> First _____ Middle _____ Last _____			2. Social Security# _____			4. Date of Birth Mo. _____ Day _____ Yr. _____		
			3. ID Number _____					
5. Insured's Address Street _____			City _____			State _____ ZIP _____		
6. Insured's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			7. Job Description and Duties _____					
8. If disability is due to an accident, did injury occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No								
9. I AUTHORIZE ANY PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, DRUG AND ALCOHOL TREATMENT FACILITY, OTHER HEALTH FACILITY, CONSUMER REPORTING AGENCY, THE MEDICAL INFORMATION BUREAU, SOCIAL SECURITY ADMINISTRATION, INSURANCE OR REINSURANCE COMPANY, OR EMPLOYER TO RELEASE ANY AND ALL MEDICAL AND NON-MEDICAL INFORMATION ABOUT ME IN ITS POSSESSION TO COMPANION LIFE INSURANCE COMPANY OR ITS LEGAL REPRESENTATIVES. MEDICAL INFORMATION MEANS ALL INFORMATION IN THE POSSESSION OF OR DERIVED FROM PROVIDERS OF HEALTH CARE REGARDING MY MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, OR TREATMENT. I UNDERSTAND THAT COMPANION LIFE WILL NOT RELEASE ANY INFORMATION OBTAINED TO ANY PERSON OR ORGANIZATION EXCEPT TO REINSURANCE COMPANIES, THE MEDICAL INFORMATION BUREAU, OR OTHER PERSONS OR ORGANIZATIONS PERFORMING BUSINESS OR LEGAL SERVICES IN CONNECTION WITH MY APPLICATION, CLAIM, OR AS MAY BE LAWFULLY PERMITTED, OR AS I MAY FURTHER AUTHORIZE. I KNOW THAT I MAY REQUEST AND RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I AGREE THAT THIS AUTHORIZATION SHALL BE VALID FOR THE DURATION OF MY CLAIM.								
SIGNATURE OF EMPLOYEE _____ PHONE NO. _____ DATE _____								

**PART II – PHYSICIAN INFORMATION**

10. Date first treated for this disability Mo. _____ Day _____ Yr. _____			11. Dates certified disabled and unable to work From: Mo. _____ Day _____ Yr. _____ Thru Mo. _____ Day _____ Yr. _____						12. If hospitalized, date admitted Mo. _____ Day _____ Yr. _____		
13. Nature of Disability <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Maternity (If Accident or Maternity, please complete reverse side of this form.)											
14. Diagnosis _____			15. Diagnosis Code _____			16. Prognosis _____					
17. <b>Physical Findings</b> (list all test results, or enclose test)											
Test _____			Date _____			Results _____					
Test _____			Date _____			Results _____					
Blood Pressure (Systolic) _____			(Diastolic) _____			Date _____					
Remarks: _____											
<b>TREATMENT</b>											
Date of onset of this condition _____ List all dates of treatment for this condition since patient ceased work _____ Date of next office visit _____											
Has patient been referred to any other physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s) _____											
If "Yes," name and address _____ Specialty _____											
Nature of treatment for this condition (including surgery/medications) _____											
Was patient hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date(s) admitted _____ date(s) discharged _____											
Name and address of hospital(s) _____											
Was surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date _____ Procedure _____ CPT Code _____											
Progress (please check one) <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed											
18. <b>IMPAIRMENT</b>											
What are the patient's current physical limitations and restrictions?											
<input type="checkbox"/> No limitation of functional capacity; capable of heavy work, no restrictions. (Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)											
<input type="checkbox"/> Medium manual activity. (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)											
<input type="checkbox"/> Slight limitation of functional capacity; capable of light work. (Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)											
<input type="checkbox"/> Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)											
<input type="checkbox"/> Severe limitation of functional capacity; incapable of minimal (sedentary) activity.											
What is the psychiatric impairment (if applicable)?											
<input type="checkbox"/> Inadequate information to make assessment.											
<input type="checkbox"/> Essentially good functioning in all areas. Occupationally and socially effective.											
<input type="checkbox"/> Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.											
<input type="checkbox"/> Moderate impairment in occupational functioning. Limited in performing some occupational duties.											
<input type="checkbox"/> Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.											
<input type="checkbox"/> Inability to function in almost all areas.											

**DETAILS OF ACCIDENT OR MATERNITY CLAIM – TO BE COMPLETED BY THE PHYSICIAN**

<p>19-A. ACCIDENT:</p> <p>On what date was the patient injured? _____</p> <p>Where (place) was the patient injured? _____</p> <p>_____</p> <p>How was the patient injured? _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>19-B. MATERNITY:</p> <p>Estimated Date of Delivery (EDC) _____</p> <p>Prenatal Complications _____</p> <p>_____</p> <p>_____</p> <p>Date of Delivery _____</p> <p>Postpartum Complications _____</p> <p>_____</p> <p>_____</p>
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20. I have treated the insured for the condition listed and for the period claimed. The insured has been under my continuous care.

Physician's Name and Address (Please type or print.) _____ _____ _____ Phone No. (Indicate area code.) _____ Date _____ Physician's Signature _____	Has the above patient been released to return to work? <input type="checkbox"/> Yes    Date to Return (Mo./Day/Yr.) _____ <input type="checkbox"/> No    Approximate Date of Return (Mo./Day/Yr.) _____ <input type="checkbox"/> No    Will not return to work. Disability is total and permanent. <input type="checkbox"/> Date of Next Office Visit _____
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**PART III – EMPLOYER INFORMATION**

21. Workers' Compensation: Is there possible Workers' Compensation liability?     Yes (If yes, complete this section.)     No  
 Date accident/sickness reported \_\_\_\_\_    Date Workers' Compensation claim filed \_\_\_\_\_

Current status of Workers' Compensation claim:     Approved     Denied     Pending     Not Filed  
 Name and Address of Workers' Compensation Payment Office \_\_\_\_\_

22. A. Will employee receive salary continuation, PTO, sick leave, vacation, etc.?     Yes     No  
 If Yes, please provide dates from \_\_\_\_\_ to \_\_\_\_\_.

B. Is employee subject to child support withholdings?     Yes     No    If Yes, provide appropriate documentation with claim.

23. Is employee enrolled in the Companion Long Term Disability plan?     Yes     No  
 If "Yes," effective date \_\_\_\_\_

24. Name and Address of Group	Phone No. and Area Code	25. Group No.
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26. I certify that the above insured was a full-time active employee and that he or she did not perform any duties pertaining to his or her occupation during the period claimed in block 11.

Employer's Signature \_\_\_\_\_    Date \_\_\_\_\_  
 Email Address \_\_\_\_\_

27. First Day Not at Work	28. Date Returned to Work	29. Amount of Weekly Earnings	30. Amount of Weekly Benefit
Mo.    Day    Yr.	Mo.    Day    Yr.	\$ _____	\$ _____

**INSTRUCTIONS FOR FILING CLAIM FOR WEEKLY DISABILITY BENEFITS**

The reverse of this form should be completed by the insured employee, the employer and the insured's attending physician as soon as possible after the onset of the accident or sickness for which claim is made. If accident or maternity, details must be stated above. If employee is 65 or older, please provide payroll records three months prior to last day worked.

The date we need a doctor's statement of continuing disability will be indicated on the check stub each week. To prevent delays in weekly disability payments, submit the doctor's statement to Companion Life 10 days before this date occurs.

Weekly disability checks are mailed to the employer's address.

**Please allow three business days from date of receipt for processing. When your employee returns to work, please call our Claims department at 877-676-5789 to notify us immediately and then follow up with the final claim. Notifications can be faxed to: 563-557-3360**

PHONE: 877-676-5789    FAX: 563-557-3360

Claims should be forwarded to:  
 Companion Life Insurance Company  
 Attention: Claims Department  
 P.O. Box 1535  
 Dubuque, IA 52004-1535

**By furnishing this blank form and investigating the claim, Companion Life Insurance Company shall not be held to admit the validity of any claim, or to waive or breach any terms or conditions of the policy.**

**GENERAL FRAUD WARNING: 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.**

**The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.**

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**Alabama:** 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.

**Alaska:** 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.

**Arizona:** 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.

**Arkansas:** 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.

**Colorado:** 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.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida:** 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.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** 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.

**Kansas:** Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

**Kentucky:** 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.

**Louisiana:** 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.

**Maine:** 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.

**Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Massachusetts:** 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 or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** 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 R.S.A. 638:20.

**New Mexico:** 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.

**Ohio:** 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.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

**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 such person to criminal and civil penalties.

**Rhode Island:** 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.

**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Texas:** Any person who knowingly presents a 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.

**Vermont:** Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**West Virginia:** 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.