



# **Boston Mutual Life Insurance Company 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. If you have any questions when completing this form, please call our:

**Toll Free Number - (800) 320-4445**

1. Complete "Employee - Initial Disability Benefits Claim Form" in full.
2. Have treating physician complete the "Physician - Initial Disability Claim Form" and return to you.
3. Have Employer complete the "Employer - Initial Claim Form" and return to you.
4. Submit *all* completed forms to the address below or you may fax *all* completed forms to our:

**Toll Free Fax Number - (888) 594-5729.**

**Mail To:**

**Boston Mutual Life Insurance Company**

Benefits Administration

P.O. Box 268956

Oklahoma City, OK 73126-8956



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 Benefits Administration  
 P.O. Box 268956  
 Oklahoma City, OK 73126-8956  
**Toll Free Phone # 1-800-320-4445**  
**Toll Free Fax # 1-888-594-5729**

**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 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	Dates Benefits	
							Begin	End
Other Group Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Salary Continuation	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
PTO/PPT	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Other (Bonus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			
Retirement/Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>			

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

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

Please provide 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**

**WARNING: 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 may be guilty of insurance fraud and subject to criminal and civil penalties.**

Name:	Social Security Number:	Date of Birth:
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Complete Mailing Address:	Complete Resident Address:	Telephone Number:
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Do you have dependents under age 18? Yes  No  If yes, please list dependent names and birth dates 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:
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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 <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:
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6) Please list name and phone number of treating physician(s):

7) Date Last Worked:	8) If you <i>have not</i> returned to work, what is the anticipated return date?	9) If your request for benefits is approved, do you want Federal Taxes withheld from each benefit check? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date Returned to Work:	<input type="checkbox"/> Full Time: _____ <input type="checkbox"/> Part Time: _____	If yes, please indicate dollar amount below: (Minimum amount required is \$87 per month.) \$ _____

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

Social Security - Disability <input type="checkbox"/>	Retirement <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____	V.A. Benefits	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____
Dependent Social Security		Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____	Sick Leave or Wage Continuation	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____
State Disability		Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____	Retirement (normal, early, or disability)	Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____
Other Group Disability Coverage		Yes <input type="checkbox"/> No <input type="checkbox"/>	\$ _____			

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

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize the entities specified below to disclose any information about my entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing Boston Mutual Life Insurance Company (BMLIC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation carrier.

**NOTICE:** Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in the caveat will prohibit this authorization from including the fact that you have AIDS.

**I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial of benefits.** I understand that I may revoke this authorization at any time by writing to Boston Mutual Life Insurance Company, Benefits Administration, P.O. Box 268956, Oklahoma City, Oklahoma 73126-8956 or calling toll free 1-800-320-4445. I understand that my right to revoke this authorization is limited to the extent that BMLIC has taken action in reliance on the authorization; or, the law provides BMLIC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original. I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations.

For health insurance coverage, this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. For Arizona residents, release of HIV/AIDS released information can only be disclosed for a period not to exceed 180 days from the date shown below.

Signature : \_\_\_\_\_ Print Insured's/Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Please retain a copy for your personal records, or you may request a copy from our company.*



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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: ICD9 Code:

Diagnosis: ICD9 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:

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:

Form with fields for: Attending Physician's Name, 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.