Pierce Insurance Agency

800-421-3142

HOW TO FILE A CLAIM

PROFESSIONAL INSURANCE DISABILITY CLAIMS

When you need to file a PIC Disability claim:

1. The claim packet contains a claim form, an authorization form, and a request for a list of providers.
2. FULLY COMPLETE the Claimant's portion of the claim form. Please sign and date the authorization. Include your policy number and social security number.
3. Have your Employer FULLY COMPLETE and SIGN the Employer's section of the claim form.
4. Have your Doctor FULLY COMPLETE the attending Physician's portion of the claim form.
5. In order to assist us in reviewing your claim as quickly as possible, please complete the Authorization for Member Initiated Request for Release of Protected Health Information.
6. Send the fully completed forms to the address below or fax to Professional Insurance at 402-479-8937.
7. Do not complete and/or submit your claim form prior to your disability.
8. To check the status of your claim call 800-289-1122.
9. If you need additional assistance with your claim contact the Pierce Agency at 800-421-3142.
10. If a disability claim and admitted to the hospital or if you have first hospital confinement, please ask the hospital for a UB04 or UB92 bill.

Professional Insurance Company
Employer Service Group
Claim Department
P.O. Box 85656
Lincoln, NE 68501-5656

Vision ✦ Focus ✦ Strength

Professional Insurance Company

In California, PIC Life Insurance Company

P.O. BOX 85656
LINCOLN, NE 68501-5656

800-289-1122

Claim No. _____

Policy Nos. _____ _____

CLAIMANT'S STATEMENT: Complete for all claims. ***For Cancer Policy, please submit Pathology Report.***

Policyholder's Name _____ Date of Birth _____

Address _____ Home Phone ( ) _____

Social Security No. _____

Employer _____ Occupation _____

Answer if claim is on dependent: Dependent's Name _____ Relationship _____ Date of Birth _____

Is dependent employed? Yes ☐ No ☐ Employer _____

Is dependent a student? Yes ☐ No ☐ School _____ Dependent SS# _____

1. CLAIM IS FOR Accident ☐ Illness ☐ Nature of illness/injury _____
2. Date of accident or 1st sign of illness _____ If claim is for an accident, describe how and where it occurred: _____
3. Has claim been made or will claim be made under any Worker's Compensation or Employers Liability Law? Yes ☐ No ☐
4. Were you hospitalized? Yes ☐ No ☐ If yes, give dates, from _____ (Mo Day Yr) to _____ (Mo Day Yr)

   Name/Address of Hospital _____

   If you were hospitalized, please send a copy of the hospital bill.
5. List all Doctors you have seen for this condition.

Name	Address	Date 1st seen

6. Have you ever had symptoms of this condition before? Yes ☐ No ☐ When _____
7. Do you have insurance with any other Company? Yes ☐ No ☐ If yes, provide

Name of Company	Policy Number(s)

IMPORTANT: PLEASE SUBMIT A COPY OF THE POLICE REPORT IF THIS CLAIM IS DUE TO A VEHICLE ACCIDENT.

Complete this Section only if you are filing for disability (loss of time from work) benefits.

1. Date you stopped working due to disability _____ Date you returned, or will return, to work _____
2. Are you confined (restricted by Drs. orders) to your home? Yes ☐ No ☐
3. Average Monthly Earnings $ _____ 4. List Job Duties _____

EMPLOYER'S STATEMENT: Must be completed for disability benefits.

1. Date of first absence due to disability _____ Date Employee returned to work _____
2. Monthly Earnings _____ Date hired _____ Date of termination, if terminated _____
3. Has claim or will claim be made for Worker's Compensation Benefits? Yes ☐ No ☐
   If yes, what is status of claim? _____
4. Will you provide "light duty" if employee is released with restrictions? Yes ☐ No ☐

Name of Employer _____ Phone number of Employer ( ) _____

Authorized Signature _____ Title or Position _____ Date _____

AUTHORIZATION TO OBTAIN INFORMATION: I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, medical information bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish to Professional Insurance Company (or its representatives) and to permit them to examine and copy any such information. I understand that Professional Insurance Company may disclose the information in connection with underwriting or claims processing with the company. A copy of this authorization, or the original, shall be valid for ninety (90) days from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF COMMITTING A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECT TO CRIMINAL PROSECUTION.

Claimant Signature _____ Date _____

THIS CLAIM REPORT IS USED FOR ANY TYPE OF HEALTH CLAIM AND MUST BE RETURNED TO
PROFESSIONAL INSURANCE COMPANY, P.O. BOX 85656, LINCOLN, NE 68501-5656 PHONE 800-289-1122

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS

INSURED'S NAME AND ADDRESS IF PATIENT IS A DEPENDENT

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

For routine FIRST-AID claims, this side is not usually required, if a copy of the bill showing Patient's name, diagnosis, charges, and date incurred is furnished along with Claimant's Statement on reverse side.

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐

3. IF CONDITION IS DUE TO ACCIDENT, PLEASE GIVE DETAILS OF ACCIDENT.

4. IS CONDITION DUE TO PREGNANCY? YES ☐ NO ☐ IF YES, EXPECTED DATE OF DELIVERY _____ DATE OF LMP _____

5. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL). IF A PREVIOUS FORM HAS BEEN SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.

Date of Services (Mo. Day, Yr.)	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code - If used (If code other than CPT used, give name)

6. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

7. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE:

9. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐ IF NO, DATE LAST SEEN _____

10. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO PERFORM SUBSTANTIALLY ALL OF HIS/HER OCCUPATIONAL DUTIES)
FROM THROUGH

11. PATIENT WAS PARTIALLY DISABLED (ABLE TO PERFORM SOME BUT NOT ALL OF HIS/HER OCCUPATIONAL DUTIES)
FROM THROUGH

12. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

13. PATIENT WAS HOSPITAL CONFINED: FROM _____ TO _____
PATIENT WAS HOUSE CONFINED: FROM _____ TO _____
(HOUSE CONFINEMENT IS THE INABILITY TO LEAVE THE HOUSE EXCEPT TO OBTAIN MEDICAL TREATMENT OR TO ENGAGE IN MEDICALY PRESCRIBED ACTIVITIES THAT ARE THERAPEUTIC IN NATURE.)

14. DOES PATIENT HAVE OTHER HEALTH COVERAGE? IF "YES" PLEASE IDENTIFY

15. WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? YES ☐ NO ☐ IF YES, PLEASE PROVIDE NAME OF REFERRING PHYSICIAN

PHYSICIAN'S NAME (PLEASE PRINT) _____ IRS IDENTIFICATION NO.* _____

PHYSICIAN'S SIGNATURE _____ DEGREE _____ DATE _____

ADDRESS _____
Street City State or Province Zip Phone Number (w/area code) Fax Number (w/area code)

*THE INSERTION OF THE IRS NUMBER IS REQUIRED BY THE INTERNAL REVENUE SERVICE.

Sun Life Financial®

Employee Benefits Group

Professional Insurance Company
(In CA, PIC Life Insurance Company)
P.O. Box 85656
Lincoln, NE 68501
800 289.1122

Medical Information for: **Policy Number:**

To assist you in making medical inquiries, I have listed below **all** the providers I have treated/consulted with within the past three years.

****PLEASE PRINT LEGIBLY and FEEL FREE TO ATTACH ADDITIONAL PAGES AS NEEDED**

PRIMARY CARE PHYSICIAN: _____

Reason for Visit: _____

Facility Name: _____

Complete Address (including zip code): _____

Dates First Consulted: _____ **Dates Last Consulted:** _____

Phone Number w/ Area Code: _____

All Other Doctors/Hospitals:

Doctor/Hospital	Reason for Visit	Specialty	Complete Address (including zip)	Phone # w/ Area Code	Dates Seen

The following **Prescriptions** have been filled (see label on prescription bottle):

Pharmacy Name	Complete Address (including zip)	Phone Number Including Area Code	Drugs Prescribed	Name of Physician	For what Condition

Date _____ **Signed** _____

Address _____

Employee Benefits Group

Professional Insurance Company
(In CA, PIC Life Insurance Company)
P.O. Box 85656
Lincoln, NE 68501
800 289.1122

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: **Claim No:** _____ **Policy No:** _____

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to Professional Insurance Company (PIC)* including any legal representative designated by PIC, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to PIC and any legal representative that it might designate.

I authorize PIC to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of PIC or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, PIC pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to PIC at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative (e.g., parent or guardian, if minor)

*In California, PIC Life Insurance Company

Sun Life Financial®

Voluntary Benefits
HIPAA Privacy Department
P.O. Box 80637
Lincoln, NE 68501

AUTHORIZATION FOR MEMBER INITIATED REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Employer	Group Account Number (Policy Number)
Primary Member/Employee Covered by the Health Plan (Last, First)	Primary Member Identification Number
Name of Person Granting Authorization (Last, First) Leave blank if same as Primary Member	Relationship to Primary Member (self, spouse, dependent child, or designated personal rep.)

My protected health information is information about me that was collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

For my purposes and at my request, I authorize the **Professional Insurance Company (in California, PIC Life Insurance Company)** to disclose my protected health information to the following individual, organization, or class of persons (e.g., group of individuals within the organization) (check all that apply):

☐ **My Employer / Plan Sponsor:**
The protected health information that may be used and disclosed to my Employer/Plan Sponsor is as follows (check all that apply):
- ☐ Eligibility
- ☐ Explanation of Benefits
- ☐ Claims Status
- ☐ Other (specify)_____

☑ **My Producer:** (specify) Pierce Insurance
The protected health information that may be used and disclosed to my Producer is as follows (check all that apply):
- ☐ Eligibility
- ☐ Explanation of Benefits
- ☑ Claims Status
- ☐ Other (specify)_____

☐ **My Spouse:** (specify) _____
The protected health information that may be used and disclosed to my Spouse is as follows (check all that apply):
- ☐ Eligibility
- ☐ Explanation of Benefits
- ☐ Claims Status or Protected Health Information related to Claims Status
- ☐ Other (specify)_____

☐ **Other:** (specify) _____
The protected health information that may be used and disclosed to this specified individual(s) is as follows (check all that apply):
- ☐ Eligibility
- ☐ Explanation of Benefits
- ☐ Claims Status
- ☐ Other (specify)_____

[If choosing "Other", describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

I understand that I may refuse to sign this authorization. I further understand that the above named health plan will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the above named health plan at the address located below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that the above named health plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the above named health plan and, by law, the above named health plan has a right to contest the coverage.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires 12 months from the date when it was signed.

_____ _____

Signature of Person Granting Authorization or Personal Representative — Date

(Last)_____ (First)_____

Printed Name

_____

Description of Personal Representative's Authority (If applicable)

You may contact me at the address below if you have questions concerning my responses in the Authorization:

_____

Street Address — City — State — Zip

Phone: (_____) _____ Email: _____

Send your completed authorization or notice of revocation to the following address:

HIPAA Privacy Department
Sun Life Voluntary Benefits
P.O. Box 80637
Lincoln, NE 68501

or

FAX to 402 479.8938

NOTE: ***All authorizations granted by this document are in addition to any uses and disclosures of protected health information permitted or required under the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations.***

This form is not to be used for obtaining records from providers for underwriting or risk rating.