



**Civil Service Employees Association, Inc. (CSEA)
Group Comprehensive Accident Insurance Plan**

ACCIDENT DISABILITY INCOME CLAIM INSTRUCTIONS
(PLEASE DETACH THIS NOTICE BEFORE MAILING AND KEEP FOR FUTURE REFERENCE)

Please answer all questions on the Member's Statement of your Disability Income claim form and sign and date the bottom of page 2 where indicated. Also sign and date the Authorization for Release of Information on page 3 and have your Medical Provider complete the rest of the form. Please see that the completed form is returned to:

Pearl Insurance
Claims Department
13 Airline Drive
Albany, NY 12205

Claims may be faxed to **518-640-8105** or emailed to **CUSTOMERCARE@PEARLINSURANCE.COM**

If you recover or return to work, please notify Pearl Insurance immediately by completing and mailing this statement to the above mailing/email address.

If you have any questions concerning your request for Accident Disability Income benefits, you may call the Office of the Administrator at 1-800-697-2732. The fax number is 518-640-8105. **Please note that we will not confirm receipt of a fax for 24 - 48 hours.**

STATEMENT OF RECOVERY OR RETURN TO WORK
(PLEASE COMPLETE FULLY AND DETACH BEFORE MAILING)

Name: _____

Residential Address: _____

Social Security No.: _____ - _____ - _____

Policy#: **G-30350-0**

I recovered:

I returned to work:

on _____ / _____ / _____
Mo Day Year

Other: _____

Date: _____

Signature: _____

Print Name: _____



**Civil Service Employees Association, Inc. (CSEA)
Group Comprehensive Accident Insurance Plan - ACCIDENT DISABILITY INCOME CLAIM FORM**

Group Policy #: G-30350

Male

Social Security No.: _____

Female

If this claim is for your spouse, please check

Spouse's Name _____

Spouse's Date of Birth: ____ / ____ / ____

Spouse's Social Security No.: _____

Member's Name: _____

Date of Birth: ____ / ____ / ____

Residential Street Address: _____
(No.) (Street) (City or Town) (State) (Zip Code)

Telephone No. Home () _____ Work () _____ Height: _____ Weight: _____

Member's Employer's Name: _____ Normal Number of Hours Worked Per Week: _____

Members' Employer's Street Address: _____ Date Last Worked: ____ / ____ / ____

Date of accident: ____ / ____ / ____
(Month) (Day) (Year)

Date first unable to work ____ / ____ / ____
(Month) (Day) (Year)

Where did the accident occur? _____

Nature of the disability _____

Please attach a copy of the Accident Report or ER Discharge Summary

Date first treated for this disability ____ / ____ / ____

Have you attempted to return to your occupation on a Part time or Full time basis since the date disability began? (If so, give details)

NAMES AND ADDRESS OF FIRST PROVIDER CONSULTED AND OTHER PROVIDERS SEEN INCLUDING YOUR PRESENT ATTENDING PROVIDER

(Name) (Address) Telephone No. Treated From ____ To ____

(Name) (Address) Telephone No. Treated From ____ To ____

(Name) (Address) Telephone No. Treated From ____ To ____

(Name) (Address) Telephone No. Treated From ____ To ____

Member's OCCUPATION _____

Please fully describe the duties of the member's occupation at the time the claimant stopped working, including the percentage of time at each activity:

What are the member's daily activities at this time?

Are you receiving or will you be entitled to receive benefits from any of the following: Workers' Compensation? Yes No
State Disability? Yes No No-Fault Benefits? Yes No Other? Yes No

If "Yes", please specify: _____

If any of the above were answered "Yes", please complete the information requested below:

Policy No.	Claim No.	Name and Address	Amount of Payment

New York Residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I declare that the answers on page 1 and page 2 of this form are complete and true to the best of my knowledge. I also agree that I will advise New York Life Insurance Company of my return to any type of work and I will return payments to which I am not entitled by reason of my return to work or termination of my Covered Disability.

Date: ____ / ____ / ____
MO DAY YEAR

Member's Signature: _____
The Member or someone on his/her behalf must sign here and on the Authorization For Release Of Information



New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 8310
Sleepy Hollow, NY 10591-8310

Authorization for Release of Information

TO: All providers of medical services and supplies, employers, insurance institutions, the Social Security Administration and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying New York Life in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

Patient's Signature

Date

Print Name

Social Security No.: _____ - _____ - _____

MEDICAL PROVIDER'S STATEMENT

(The patient is responsible for the completion of this form without expense to the Company)

Notice to Provider: Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to his or her specific contract with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. PATIENT'S NAME: _____ DATE OF BIRTH: _____ / _____ / _____ (First)
(Middle) (Last) (Month) (Day) (Year)

2. CURRENT MEDICAL CONDITION(s):
PRIMARY DIAGNOSIS: _____ ICD-10 CM CODE: _____
SECONDARY DIAGNOSIS: _____ ICD-10 CM CODE: _____

3. DATE THAT SYMPTOMS FIRST APPEARED: _____ / _____ / _____
(Month) (Day) (Year)

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: _____ / _____ / _____
(Month) (Day) (Year)

DATE THAT PATIENT LAST CONSULTED YOU FOR THIS CONDITION: _____ / _____ / _____
(Month) (Day) (Year)

5. IS THIS CONDITION THE RESULT OF AN ACCIDENT? YES NO

(If "Yes", when did the accident occur)? _____ / _____ / _____
(Month) (Day) (Year)

IS THE ACCIDENT RELATED TO PATIENT'S EMPLOYMENT? YES NO

6. WAS THE PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? Yes NO

(If "YES", please provide name and address of that practitioner): _____

7. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR INJURY OR SICKNESS? YES NO

(If "Yes", please provide details and dates of prior treatment): _____

8. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? YES NO (If "Yes", provide diagnosis(es) and dates of prior treatment): _____

9. OBJECTIVE FINDINGS (Include x-rays, lab results and clinical findings.) _____

10. HAS PATIENT BEEN HOSPITALIZED? YES NO (If "YES", provide reason, hospital name and dates of confinement): _____

MEDICAL PROVIDER'S STATEMENT
(Continued From Previous Page)

11. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED: (Include surgery and medications prescribed if applicable) _____

12. HAVE YOU REFERRED THE PATIENT TO ANOTHER PRACTITIONER? YES NO (If "Yes", please provide the name and address of all applicable physicians or practitioners) _____

13. IN YOUR OPINION IS THE PATIENT ABLE TO WORK AT THIS TIME? YES NO
IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? _____

(MO) (DAY) (YEAR)

14. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES NO (If "Yes", please describe) _____

15. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:

a) THE PATIENT WAS UNABLE TO WORK FROM: _____ THROUGH: _____

(MO) (DAY) (YEAR) (MO) (DAY) (YEAR)

b) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: _____ THROUGH: _____

(MO) (DAY) (YEAR) (MO) (DAY) (YEAR)

16. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO HIS OR HER MEDICAL CONDITION (If none, indicate "NONE"): _____

17. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES NO

IF "YES" DATE RELEASED FROM YOUR CARE:

(MO) (DAY) (YEAR)

IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION:

(MO) (DAY) (YEAR)

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I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

PROVIDER'S NAME (PLEASE PRINT)

SPECIALTY

TELEPHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIPCODE

PROVIDER'S SIGNATURE

DATE SIGNED