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 Carroll & Associates, Inc.
Claims Department
12 Cornell Road
Latham, NY 12110
Claims may be faxed to **518-640-8105** or emailed to **CUSTOMERCARE@PEARLCARROLL.COM**

If you recover or return to work, please notify Pearl Carroll & Associates 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: ______________________________

(3/17)

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 ADDRRESS 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

____

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

____

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

____

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