STATEMENT OF RECOVERY OR RETURN TO WORK

DISABILITY INCOME CLAIM INSTRUCTIONS

(PLEASE DETACH THIS NOTICE BEFORE MAILING AND KEEP FOR FUTURE REFERENCE)

- Please answer all questions on the Member Statement on your Disability Income claim form
- Please provide a complete List of Providers/Hospitals that treated you for this disability.
- Date and sign both the Members Statement and the Authorization for Release of Information.
- Please have your Medical Provider complete both pages of the Medical Provider's Statement.
- Please see that the completed form is returned to:

Pearl Carroll & Associates LLC

Disability Claims Unit
12 Cornell Road
Latham, NY 12110

If you recover or return to work, please notify Pearl Carroll & Associates immediately by completing and mailing this statement to the above address or emailing to Customercare@PearlCarroll.com.

If you have any questions concerning your request for 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.**

Name: _____

Mailing Address: _____

_____

Social Security No.: _____-_____-_____ Policy G-11628

I recovered: ☐ I returned to work ☐ Date: _____
Month/Day/Year

Other (I.E. Returned to work light duty, another job etc):

_____

_____

_____

Date: _____ Signature: _____

Email Address: _____

CSEA MEMBER'S DISABILITY INCOME FORM

CLAIM TYPE: ☐ Member Disability ☐ Spouse-Coverage Disability ☐ Non-Disabling Injury
☐ Hospital Benefit ☐ Survivor Benefit

Member Name: _____ Date of Birth: _____

Social Security # _____ ☐ Male ☐ Female

Spouse Name: _____ Date of Birth: _____

Social Security # _____ ☐ Male ☐ Female

Mailing Address: _____ _____
(No.) (Street) (Apt No.)

_____
(City or Town) (State) (Zip Code)

Telephone No.: Home: ( )_____ Employer ( ) _____Height: _____ Weight _____

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

Employer's Street Address: _____
(No.) (Street) (City or Town) (State) (Zip Code)

Email Address: _____

What is the nature of your disability?_____

Is disability work related? Yes ☐ No ☐ If yes, please attach a copy of the Employee Accident Report signed by manager

Is disability due to an Injury? Yes ☐ No ☐ If "Yes", when? _____/_____/_____
Mo. Day Year

Where did it happen?_____

How did it happen? _____

Date first treated for this disability: _____/_____/_____
Mo. Day Year

Date First Unable to Work: _____/_____/_____ Date Last Worked: _____/_____/_____
Mo. Day Year Mo. Day Year

Have you attempted to return to your occupation since the date disability began? (If so, give details)

_____

If returned to work or recovered, give date: _____/_____/_____
Mo. Day Year

Returned to work: Full Time: ☐
Part Time: ☐
If Part Time, # of hours per day _____

If not returned, when do you expect to? _____/_____/_____
Mo. Day Year

Are your working a second job? If so, please provide the name and address of the company and the hours you are working.

****If disability is due to a Motor Vehicle Accident, please attach MV-104A Police Report****

**** If treated in hospital or Urgent Care Center, please attach a copy of your discharge papers****

CSEA MEMBER'S DISABILITY INCOME FORM

Member's Name _____ **Member's Social Security #**_____

Names and addresses of providers consulted and any other providers seen for treatment.

PLEASE PRINT – ***If you need more space, you may attach a sheet of paper with the additional names, addresses, and phone numbers. Be sure to include all providers, as any missing may delay your claim.***

PHYSICIANS:

Name:	**Name:**
Address:	**Address:**
City:	**City:**
State: **Zip:**	**State:** **Zip:**
Phone:	**Phone:**
Name:	**Name:**
Address:	**Address:**
City:	**City:**
State: **Zip:**	**State:** **Zip:**
Phone:	**Phone:**
Name:	**Name:**
Address:	**Address:**
City:	**City:**
State: **Zip:**	**State:** **Zip:**
Phone:	**Phone:**

HOSPITALS

Name:	**Name:**
Address:	**Address:**
City:	**City:**
State: **Zip:**	**State:** **Zip:**
Phone:	**Phone:**

PHARMACIES

Name:	**Name:**
Address:	**Address:**
City:	**City:**
State: **Zip:**	**State:** **Zip:**
Phone:	**Phone:**

CSEA MEMBER'S DISABILITY INCOME FORM

Member Name _____ Member's Social Security #_____

Please state your occupation: _____

Please attach a copy of your official job description

Please fully describe all the duties of your occupation at the time you stopped working including the percentage of time spent on each activity:

_____

_____

_____

_____

What are your daily activities?_____

_____

_____

Are you receiving or will you be eligible to receive benefits from:

Workman's Compensation?	Yes ☐	No ☐
Pension Plan?	Yes ☐	No ☐
Another Group Insurance Plan?	Yes ☐	No ☐
Individual Disability Income Policy?	Yes ☐	No ☐
Social Security Disability?	Yes ☐	No ☐

If "Yes" insert policy number, claim number and address of insurance company or organization providing such benefits and amount of payment.

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

I declare that the answers on Page 1, Page 2 and Page 3 of this form are complete and true to the best of my knowledge and belief. I also agree that I will advise the New York Life Insurance Company of my return to any type of work and that I will return any payments to which I am not entitled by reason of my return to work or termination of my disability.

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.

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 Form.

Please see that the completed form is returned to:

Pearl Carroll & Associates LLC
12 Cornell Road – Disability Unit
Latham, NY 12110
Fax # 518-640-8105 or email to Customercare@PearlCarroll.com

Authorization for Release of Information

TO: All providers of medical services and supplies, pharmacy related service organizations, prescription history database suppliers, employers, insurance institutions, the Social Security Administration and other organizations.

I authorize release to New York Life Insurance Company or their representative, Pearl Carroll & Associates LLC, any independent claim administrators, consulting health professionals, pharmacy related service organizations 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) and prescription records. This information will be used to evaluate claims for benefits.

In Oklahoma, the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

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
_____	_____
Address	City, State Zip
_____	_____
Email Address	Phone Number

Medical Records Release to: Datafied Inc. 1210 N. Jefferson St. Suite P Anaheim, CA 92807

Please see that the completed form is returned to:

Pearl Carroll & Associates LLC
12 Cornell Road – Disability Unit
Latham, NY 12110
Fax # 518-640-8105 or email to Customercare@PearlCarroll.com

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:** _____ **SOCIAL SECURITY NO.:** _____
   (First) (Middle) (Last)

   DATE OF BIRTH: _____/_____/_____
   (Mo) (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 OR ACCIDENT HAPPENED: _____/_____/_____
   (Mo) (Day) (Year)

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

5. DATE YOU LAST TREATED THE PATIENT: _____/_____/_____
   (Mo) (Day) (Year)

6. IS THIS CONDITION RELATED TO PATIENT'S EMPLOYMENT? YES ☐ NO ☐

7. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? YES ☐ NO ☐
   (If "Yes", please provide the name and address of that practitioner): _____

   _____

8. OBJECTIVE FINDINGS ***(Include x-rays, lab results and clinical findings. If pregnancy, also give LMP and EDC)***:

   _____

   _____

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

10. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED: ***(Include dates and type of surgery and any medications prescribed if applicable):*** _____

    _____

    _____

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

    _____

12. 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)

MEDICAL PROVIDER'S STATEMENT

PATIENT'S NAME: _____ **SOCIAL SECURITY NO.:** _____
(First) (Middle) (Last)

13. 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):*** _____

_____

14. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:

a) THE PATIENT WAS TOTALLY DISABLED FROM: _____/_____/_____ THROUGH: _____/_____/_____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

b) THE PATIENT WAS PARTIALLY DISABLED FROM: _____/_____/_____ THROUGH: _____/_____/_____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

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

_____

_____

16. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES ☐ NO ☐
IF "YES" DATE RELEASED FROM YOUR CARE: IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION:

_____/_____/_____ _____/_____/_____
(*Mo) (Day) (Year)* *(Mo) (Day) (Year)*

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**.**

MEDICAL PROVIDER'S DECLARATION AND SIGNATURE

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 ZIP CODE

_____ _____
PROVIDER'S SIGNATURE DATE SIGNED

Please return completed forms to:

Pearl Carroll & Associates LLC
12 Cornell Road – Disability Unit
Latham, NY 12110
Fax # 518-640-8105 or email to CustomerCare@PearlCarroll.com