USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200

IMPORTANT READ CAREFULLY

1. **This form must be signed by you and completed and signed by your physician.**
2. **Return to us by: _____ to avoid interruption of your weekly disabilty income benefits.**

UPDATE FORM
SHORT TERM DISABILITY

	Claim Number:
	Employer:
	Home or Other Daytime Phone Number:

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 such information to USAble Life (or its representatives) and to permit them to examine and copy such information. I understand that USAble Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with the underwriting or claims processing with the company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.

Date: _____ Signature of Insured: _____

ATTENDING PHYSICIAN'S STATEMENT
Please answer all questions.

Diagnosis & Concurrent Conditions:	**ICD Code:**	**If pregnancy, advise delivery date:**

How long was or will patient be unable to work? From _____ Through _____

Date patient can return to work: _____

Dates of Treatment:

Date of first visit _____ Date of last visit _____

Frequency of visits _____ Date of next appointment _____

Nature of Treatment (Include surgery, medications, etc.):

Current Restrictions and Limitations:

Describe any circumstances causing disability to be prolonged:

Physician's Signature	**Provider Tax ID #**	**Date**
Physician's Name		**Degree**
Address		**Telephone ( )**
City	**State**	**ZIP**

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida
Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania
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 subjects such person to criminal and civil penalties.

Retain for your records.