# Madison National Life

**Insurance Company, Inc.**
P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

## EMPLOYER'S STATEMENT OF CLAIM FOR BENEFITS

**As your disability insurance provider, we are committed to assisting your employee in a return to productive employment. Please complete the following information thoroughly, as this will allow us to accurately evaluate this claim and assist your employee with a successful return to work. An incomplete claim form will not be accepted.**

Employee's name:_____ Social security number: _____

Address:_____
Street City State Zip Code

Telephone number:_____ Date of Birth:_____

## EMPLOYEE INFORMATION

Employee's date of hire:_____ Date employee became insured for benefits: _____

What was the employee's permanent job on his or her last day of work? _____

How long had the employee been in this job?_____ Last date employee actually worked:_____

On the last day worked did the employee work a full day? ☐ Yes ☐ No If no, how many hours were worked? _____

Why did your employee stop working? _____

_____

_____

Were there any changes to your employee's job responsibilities prior to the last day of work?

☐ No ☐ Yes If yes, what were the changes and when were they made?_____

_____

What is your employee's regularly scheduled work week? _____Hours per week. _____Hours per day. Hourly wage if applicable:_____

What was your employee's Basic **ANNUAL** Salary as of his/her last day of work? $_____

Has your employee returned to work? ☐ No ☐ Yes If yes, Part-time date:_____Full-time date:_____

If employee returned to work, he / she returned: ☐ At full capacity ☐ With work restrictions. If the employee returned with restrictions,

please indicate the specific restrictions: _____

_____

## SALARY / OTHER INCOME / TAX INFORMATION

**Type of benefit this claim is being filed for? (Please check all applicable claims):**

☐ **Short Term Disability benefits** ☐ **Long Term Disability benefits** ☐ **Life Insurance Waiver of Premium benefits**

If claim is for Life Insurance Waiver of Premium benefits, please indicate:
Effective date of coverage**:**_____Basic Coverage Amount: $_____
Supplemental Coverage Amount: $_____Total Number of dependents:_____spouse_____children

How many contract days does this employee work:_____ Total number of sick days employee has:_____

**If your employee worked based on contracted days, please provide a calendar documenting each contract day.**

**CONTINUED ON REVERSE SIDE**

**Name of Employee:**_____ **Date of Birth**_____

## SALARY / OTHER INCOME / TAX INFORMATION CONTINUED

Has your employee received or will he/she receive any pay from the following: ☐ Salary continuance ☐ Sabbatical Pay ☐ Sick Leave

If you checked any of the above please complete the following:

The employee received pay from _____ to _____ in the amount of $_____ per ☐ Week ☐ Month.

Is the employee's disabling condition work-related? ☐ No ☐ Yes ☐ Unknown

Has a claim been filed with Workers' Compensation? ☐ No ☐ Yes ☐ Unknown

If yes, what is the current status of the Workers' Compensation claim? ☐ Approved ☐ Denied ☐ Currently Disputed

**Please send any Worker's Compensation claim information that you may have including benefit payment information if applicable.**

If this is an STD claim, does the employee pay any of the STD insurance premium? ☐ No ☐ Yes If yes, the contribution is: ☐ Pre-tax ☐ Post-tax If "Post-tax", _____% paid by employer _____% paid by employee. $_____ employer, $_____ employee

If this is an LTD claim, does the employee pay any of the LTD insurance premium? ☐ No ☐ Yes If yes, the contribution is: ☐ Pre-tax ☐ Post-tax If "Post-tax", _____% paid by employer _____% paid by employee. $_____ employer, $_____ employee

**(Note: If employee paid disability premium is pre-tax, we will deduct FICA tax as if the employer was paying 100% of the disability premium.)**

To the best of your knowledge, is your employee receiving, or entitled to receive benefits from any of the following as a result of this disability:

☐ Social Security ☐ Other Government Agency ☐ Teachers or Public Employees' Retirement System
☐ Statutory Disability Income, e.g. Workers' Compensation ☐ Any other Disability or Retirement Plan (Employer-sponsored or not)

**FOR ANY YES ANSWER PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Name and address of carrier or administrator:_____ Telephone Number:_____

## RETURN TO WORK CONSIDERATIONS (Complete if employee has not yet returned to work)

Does your company/organization have a return-to-work policy for disabled employees? ☐ No ☐ Yes

Do you, or does someone from your company/organization, maintain contact with your employee? ☐ No ☐ Yes Frequency? _____

Can you provide transitional job duties for your employee to allow a gradual return to work? ☐ No ☐ Yes

Has this information been communicated to your employee's physician? ☐ No ☐ Yes

Have you discussed a return to work with your employee? ☐ No ☐ Yes What is the anticipated return to work date? _____

What is the name, telephone number and title of the supervisor we should contact if we identify a rehabilitation or return-to-work option?

_____

Name Title Telephone Number

Would you like a Vocational Rehabilitation Case Manager to assist your employee in the return to work process? ☐ No ☐ Yes

Do you have any other comments which might help us better manage this claim? _____

_____

# PLEASE ATTACH A JOB DESCRIPTION OUTLINING THE JOB DUTIES AND PHYSICAL DEMANDS OF THIS EMPLOYEE'S OCCUPATION

## CONTACT INFORMATION

Employer's Group Name:_____ Group/Policy number: _____

Mailing address:_____
Street City State Zip Code

Name and title of individual completing this form (please print): _____

Telephone number:_____ Fax number: _____

Email address: _____

**I have received and read the fraud warning statements provided with this form.**

**Signature**_____ **Date** _____

# Fraud Warnings

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin and Wyoming.

**ALABAMA WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**ARIZONA WARNING:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CALIFORNIA WARNING:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a 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 WARNING:** 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 damage. 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.

**DISTRICT OF COLUMBIA WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**FLORIDA WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

**MAINE WARNING:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

**NEW HAMPSHIRE WARNING:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NEW JERSEY WARNING:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW MEXICO WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines, and criminal penalties.

**OHIO WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**PENNSYLVANIA WARNING:** 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.

**TENNESSEE WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**VIRGINIA WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**WASHINGTON WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature:_____ Date:_____