Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Short Term and Long Term Disability Claim Form

Group Disability Claim Application

Select Which Benefit(s) You Are Applying For

☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

Disability Insurance Specialists (DIS) provides disability claim services for Nationwide Life Insurance Company group disability policies.

SEND TO:
DISABILITY INSURANCE SPECIALISTS
P.O. BOX 29
BLOOMFIELD, CT 06002
TEL: (800) 654-3826
FAX: (860) 769-6981

General Instructions: Please Read this Page Before You Fill Out the Claim Form

To file an application for disability benefits, please follow the instructions below to avoid unnecessary delays.

This claim application requests information that is necessary for the speedy and accurate administration of your claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization (to be completed by you, the employee)
Section 2: Employee Statement
Section 3: Employer Statement
Section 4: Physician Statement

When ALL sections of this form have been completed, please fax or mail it to us. Use the fax number or address above that corresponds to the type of disability claim for which you are applying.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

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Short and Long Term Disability Claim Form
Authorization and Disclosures

Section 1: To Be Completed by Employee

TO:

- Physicians and Other Health Care Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
  Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration ("SSA"), Internal Revenue Service, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers, including worker's compensation
- insurers or administrators, and Pre-Paid Health Plans
- Pharmacies and Pharmacy Benefit Managers
- State Vocational Rehabilitation Agencies and other providers of rehabilitation services
- Medical Information Bureau (MIB) or other companies, which collect health and insurance information
- Attorney Representatives, or advocates for SSA benefits

You are authorized to provide information related to my health condition and job modifications/accommodations with my current or future employer to:

- Disability Insurance Specialists (DIS);
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

This form allows the release of the following information, collectively referred to as "Information":

- Records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations and prescriptions;
- Employment-related information, including any claims for workers' compensation;
- Income and tax-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering benefits for short term disability, long term disability, salary continuation, workers' compensation, which are excepted benefits under HIPAA, or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), developing a vocational rehabilitation plan, and other purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program under which I may be a participant, employers, reinsurers, the SSA, claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain in force for a period of 24 months or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address above. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of DIS to process my claim and may lead to the denying or terminating of my claim for benefits.

Claimant's Signature:_____ Date:_____

Claimant's Full Name:_____ Date of Birth:_____

If the insured is unable to sign, an authorized representative may sign below for the insured.

Representative Signature:_____ Date:_____

Name and Description of Representative's Authority to Sign:_____

Short and Long Term Disability Claim Form
State Fraud Notices

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of 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.

(Alaska) A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under 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.

(Arkansas) 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 fines and confinement in prison.

(California) 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) 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.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(District of Columbia) 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 fines and confinement in prison.

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

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Kentucky) 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**) 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 fines and confinement in prison.

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

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

(New Mexico) 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.

(New York) 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 $5,000 and the stated value of the claim for each such violation.

(Ohio) 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.

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(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.

(Rhode Island) 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 fines and confinement in prison.

(Tennessee) 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.

(Texas) 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.

(Virginia) 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) 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.

(West Virginia) 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 fines and confinement in prison.

(All Other States) 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/or civil penalties

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Short and Long Term Disability Claim Form
Employee Statement

Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1. Employee Name (First, MI, Last)			**2.** Social Security Number
Residential Address – No P.O. Box (Street Name/Number)			**3.** Phone Number
City, State, Zip			**4.** Date of Birth
5. Height	**6.** Weight	**7.** □ Male □ Female	**8.** Employer Name
9. Occupation	**10.** List Occupation Duties		
11. Date of Accident or date of first symptoms		**12.** Last Day Worked	**13.** Are you unable to work due to (check one): □ Injury □ Illness □ Pregnancy

14. Date you Retured to Work:_____ □ Full Time □ Part Time

15. If you have not returned to work, when do you expect to return?_____ □ Full Time □ Part Time

16. Describe in detail, when, where and how accident occurred, or nature of disability and first symptoms

17. Is your accident or illness related to your occupation? □ Yes □ No
If yes,explain:

18. Have you filed a Workers' Compensation Claim? □ Yes □ No If no, do you intend to? □ Yes □ No
If no, explain:

19. When were you first treated for your illness or accident? List name and address of Hopsital/Doctor Below.

Hospital	Address	Date(s)
Doctor	Address	Date(s)

20. Have you ever had the same or similar condition in the past? □ Yes □ No List name and address of Hopsital/Doctor Below.

Hospital	Address	Date(s)
Doctor	Address	Date(s)

21. Are you receiving any of the following?

	Amount	Begin Date	End Date		Amount	Begin Date	End Date
Worker's Comp	$_____	_____	_____	Unemployment	$_____	_____	_____
Social Security	$_____	_____	_____	Other (Indiv or Group)	$_____	_____	_____
State Disability*	$_____	_____	_____	Auto Insurance Wage			
Pension Plan	$_____	_____	_____	Replacement*	$_____	_____	_____

*If yes, please provide name and address of insurer below.

Insurer Name(s)	Address

22. □ Single □ Married □ Divorce □ Widowed	**23.** If married, spouse's name and Social Security No.	**24.** Spouse's Date of Birth
25. Is Spouse Employed? □ Yes □ No	**26.** List Children under age 25 (Names and Dates of Birth)	

27. If benefits are approved, do you want the minimum $20.00 per week for STD and/or $88 per month for LTD withheld from your check for Federal Income Tax purposes? □ Yes □ No
If you want more withheld, please state dollar amount you want withheld $_____

28. If benefits are approved, please select one of the following benefit payment options:

☐ **I authorize Nationwide to deposit my disability proceeds into my personal bank account.** As a convenience to me, I authorize Nationwide Insurance and its authorized representative, DIS, Bloomfield, CT (TIN #), to deposit claim payments and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below.

Bank Name_____ Name on Bank Account_____

Checking ☐ Savings ☐

If selecting Checking Account, please submit ***a voided blank check.***
If selecting Savings Account, please submit ***a copy of a bank statement, direct deposit authorization form or other documentation showing the routing and account numbers.***

Authorized Signature_____ Date_____

☐ **Please send a lump sum check to me for all disability proceeds.**

(New York) 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 have read and understand the fraud warning statements included on this group disability application form. The above statements are true and complete to the best of my knowledge and belief (your signature is required for benefit consideration).

Signature ►	Date

Nationwide is on your side

Short and Long Term Disability Claim Form
Employer Statement

Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1. Employee Name (First, MI, Last)		**2.** Social Security Number
Address		**3.** Date of Birth
City, State, Zip	What State Does the Employee **Work** in?	**4.** Regularly Scheduled Hours Per Week

5. Date of Hire	**6.** Employee's STD Coverage Effective Date	**7.** Employee's LTD Coverage Effective Date	**8.** Occupation (Include copy of job description)

9. Policy No.	**10.** Policy Divison No.	**11.** Policy Class

12. Employee's Work Schedule: □ Full Time □ Part Time □ Exempt □ Non-exempt □ Seasonal

13. Check Regular Workdays: □ Sun □ Mon □ Tues □ Wed □ Thurs □ Fri □ Sat

14. If not at work when disability began, check status and provide date

□ Terminated □ Leave of Absence □ Other:_____
□ Laid Off □ Sick Leave
□ Vacation □ Resigned Date:_____

15. How was employee paid? (check frequency and types)

Frequency: □ Weekly □ Bi-weekly □ Semi-Monthly □ Monthly

Types: □ Hourly □ Bonus □ Salary □ Commision

16. Salary Prior to Date last Worked

Base Weekly Wages $ _____
W-2 Earnings $ _____
Overtime $ _____
Commissions $ _____
Bonus $ _____

17. Date Last Salary Increase

18. Employee Work Schedule at Time Last Worked

_____ Days per week

_____ Hours per week

19. Is employee receiving or eligible to receive?

California SDI	□ Yes	□ No
Hawaii TDI	□ Yes	□ No
New Jersey TDB	□ Yes	□ No
New York DBL	□ Yes	□ No
Puerto Rico PDB?	□ Yes	□ No
Rhode Island TDI?	□ Yes	□ No

20. Date Last Worked	**21.** Hours Worked That Day	**22.** Has Employee Returned to Work? □ Yes □ No If Yes, Date:_____ □ Full Time □ Part Time

23. Date Paid Through:_____ For: □ Salary Contribution □ Vacation □ Accrued Sick Pay

24. Does employee contribute toward the STD premium? □ Yes □ No If yes, □ Pre-Tax □ Post-Tax

If Post Tax, _____% paid by employer _____% paid by employee

25. Does employee contribute toward the LTD premium? □ Yes □ No If yes, □ Pre-Tax □ Post-Tax

If Post Tax, _____% paid by employer _____% paid by employee

26. Employee is eligible for:	Yes	No	If yes, Weekly or Monthly Amount	Wk	Mo	Provider Name/Address	Date Benefits Begin	Through
Salary Contribution	□	□	$	□	□			
Disability Pension	□	□	$	□	□			
Retirement Pension	□	□	$	□	□			
State Disability	□	□	$	□	□			
Unemployment	□	□	$	□	□			
Social Security	□	□	$	□	□			
Worker's Comp	□	□	$	□	□			
Has Worker's Comp claim been filed?	□	□	If Worker's Compensation has been denied, please submit a copy of denial with this claim.					

27. Does your company have a rehire or return to work policy for disabled employees? □ Yes □ No
What is the name of the person we should contact if we identify a return to work option?

28. Name/address of the employee's medical insurance carrier or HMO (provide policy or ID No.)

29. Employer's Name		Phone Number	
Address	City	State	Zip

(New York) 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 have read and understand the fraud warning statements included on this group disability application form. The above statements are true and complete to the best of my knowledge and belief (your signature is required for benefit consideration).

Name of Employer's Authorized Representative (print)	Title	Phone Number
Signature ▶		Date

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Short and Long Term Disability Claim Form
Physician Statement

Section 4: To Be Completed By Physician (Please Print)

Patient Name (First, MI, Last)	Date of Birth	Social Security Number

Height	Weight	Blood Pressure (last visit)

1. Patient is/was unable to work due to (check one): □ Injury □ Illness □ Pregnancy

2. Diagnosis (include complications and ICD 10):

For Normal Pregnancy, complete items 3-6, then skip to item 25

3. What was LMP date?	**4.** What is the expected/actual date of delivery and type?	**5.** Date First Treated	**6.** Date Last Treated

For all conditions except Normal Pregnancy, complete the following items

7. When did symptoms first appear or accident happen?	**8.** Date you advised patient to stop working?	**9.** Is condition due to injury or illness arising out of patient's employement? □ Yes □ No

10. Has patient ever had same or similar condition? □ Yes □ No
If yes, state when and describe.

11. Date of first visit	**12.** Date of Last Visit	**13.** Frequency of Visits/Date Next Visit

14. Objective Findings (X-rays, EKG's, lab data and clinical findings)	**15.** Subjective Symptoms

16. Nature of Treatment

17. Names and Addresses of Other Physicians

18. Has patient been hospitalized? □ Yes □ No From_____ to _____
If yes, please provide name and address.

19. Restrictions (what the patient **SHOULD NOT** do)	**20.** Limitations (what the patient **CANNOT** do)

21. Mental impairment (if applicable). Please provide 5 AXIS Diagnosis

I.	IV.
II.	V.
III.	

22. If this is a cardiac condition, what is the functional capacity (American Heart Association)?
□ Class 1 – No Limitation □ Class 2 – Slight Limitation □ Class 3 – Marked Limitation □ Class 4 – Complete Limitation

23. Has maximum medical improvement been achieved? □ Yes □ No
If no, when do you expect a fundamental change? □ 1-2 weeks □ 3-4 weeks □ 5-6 weeks □ More than 6 weeks

24. Have you discussed a return to work plan with your patient? □ Yes □ No

The date you released your patient to return to work:_____ □ Full-time □ Reduced hours □ Number of hours_____

Please identify your recommendations for any job modification that would enable the patient to return to work.

25. Physician Name (Please Print)	Degree

Specialty	Phone Number	Fax Number

Address	City	State	Zip

Signature (No Stamp) ▶	Tax ID No.	Date