



Phone Number: (888) 381-9727
Fax: (877) 404-6457

NOTE: All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

NOTICE OF CLAIM - Employer Instructions

Approximately 6 to 8 weeks before the end of the elimination period:

- A. Complete the Employer's Report of Claim in full;
- B. Give claim form to claimant for completion; and
- C. Request copy of awards from other sources of benefits: Social Security, Workers' Compensation, retirement, state disability, and others.

When claimant returns the form to you:

- A. Attach:
 - Job description (detailed duties)
 - Proof of enrollment (only for contributory coverage)
 - Documentation of earnings if other than straight salary
 - If Workers' Compensation claim filed, include copy of First Report of Accident and the decision
- B. Return, together with all attachments, to Blue Cross and Blue Shield of Oklahoma (BCBSOK) at the address shown above.

APPLICATION FOR LTD BENEFITS - Employee Instructions

- A. Complete employee claim statement in full, and be sure to sign the Authorization. This will allow BCBSOK or its representative to secure additional information if necessary to make a decision on your claim.
- B. Give this form to the physician treating you. (If more than one physician is treating you, obtain additional forms from your employer.)

When your physician returns the completed form to you:

- A. Attach a copy of Social Security and other income entitlement awards; and
- B. Return to your employer.

Electronic Funds Transfer (EFT) Authorization

If you are eligible for monthly benefits, and wish to receive benefits via direct deposit, complete the attached form and return as indicated.

APPLICATION FOR LTD BENEFITS - Physician Instructions

As soon as the claimant gives you this form:

- A. Complete the APS on page 4 of the form in its entirety, being careful to answer each question. If the answer is none, or if the question is not applicable, please so indicate.
- B. As soon as you have fully completed the form, sign, date, and return to the claimant. Our timely review of this claim for disability benefits depends on you. Thank you for your prompt response.

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. (Not enforceable in Oregon or Virginia.)



Employer Report Of Claim

To be Completed by Employer

CLAIMANT	1. Employee Name (Last) (First) (M.I.)			2. Social Security No.	3. Date of Birth	
	4. Address			City	State	Zip Code
EMPLOYMENT	5. Insurance Class		6. Employee Date of Hire		7. Date Employee Became Insured for LTD	
	9. Occupation at Time Last Worked (attach job description)		10. Work Schedule at Time Last Worked No. of Days Per Week _____ No. of Hours Per Day _____			
	11. Reason for stopping: _____ Date _____ <input type="checkbox"/> Sickness <input type="checkbox"/> Granted LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Other <input type="checkbox"/> Vacation			12. Has Employee Returned to Work: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time Date _____ Date _____		
	13. How is Employee Paid: <input type="checkbox"/> Straight Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Commissions Only <input type="checkbox"/> Salary & Commission <input type="checkbox"/> Salary & Bonus			14 Employee's Basic Monthly Earnings \$ _____ LTD Benefit _____		
INCOME	Does the Employee contribute towards the cost of this LTD insurance: <input type="checkbox"/> yes <input type="checkbox"/> no If "Yes,": <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax If "Post-tax," _____ % premium dollars paid by employer, _____ % paid by claimant. See IRS Publication 15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting and/or IRS Revenue Ruling 2004-55 for more information on calculating the taxable percentage.					
	16. Has the Insured Received Other Disability Payments Since Time Last Worked Salary Continuation: _____ Short Term Disability: _____ Sick Leave: _____ <input type="checkbox"/> Yes Wkly. Amt. \$ _____ <input type="checkbox"/> Yes Wkly. Amt. \$ _____ <input type="checkbox"/> Yes Wkly. Amt. \$ _____ Date Benefits Cease _____ Date Benefits Cease _____ Date Benefits Cease _____ <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No					
OTHER BENEFITS	17. Did Claim Result From Job Activity: <input type="checkbox"/> Yes Explain _____ <input type="checkbox"/> No		18. Has Workers' Compensation claim been filed: <input type="checkbox"/> Yes (Enclose copy of 1st report of accident) <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Denied (Enclose copy of denial)		19. Workers' Comp. Weekly Amount: \$ _____	
	20. Is Employee Covered by Employer Sponsored Retirement Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Does Retirement Plan Contain a Disability Provision: <input type="checkbox"/> Yes <input type="checkbox"/> No			
RETIREMENT	22. Is Employee or will Employee be Eligible for a Disability or Retirement Pension: <input type="checkbox"/> Yes If Yes: <input type="checkbox"/> Disability Monthly Amt. \$ _____ (Please Enclose Copy of Summary Plan Description) <input type="checkbox"/> Retirement Commence Date of Benefits _____ <input type="checkbox"/> No <input type="checkbox"/> Other _____					
	NOTE: If any Portion of this Pension Benefit is Attributable to the Employee's Contribution, Please Provide Details Including the Percentage of His/Her Contribution to the Total Contribution.					
CERTIFICATION	23. Employer Name (association and policyholder, if other)		24. Telephone No.	25. Group Policy No.		
	26. Address		City	State	Zip Code	
	27. Employer (Taxpayer) I.D. Number (EIN) _____ OR		29. Name of Person Completing this Form (Printed)			
	28. Public Employer Social Security No. 69 _____					
	30. Signature of Authorized Insurance Representative		Title	Date		



Employee Claim Statement

To be Completed by Employee

C L A I M A N T	1. Full Name (Last) (First) (M.I.)			2. Maiden Name	3. Alias Name	4. Social Security No.
	5. Phone Number	6. Date of Birth	7. Height ft. in.	8. Weight lbs.	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Address
	City	State	Zip Code	11. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Spouse's Date of Birth First Name _____
	14. Number of Children (Under age 19)			15. List Names and DOB of unmarried children in high school		

E M P L O Y M E N T	16. Employer Name			17. Group Policy No.		
	18. Occupation (List the duties of your occupation at the time of disability)					
	19. Accident or first noticed symptoms of illness on		20. I have been unable to work due to the disability since		21. I returned to work on a part-time basis on	
23. Is Your Accident or Illness Related to Your Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____			24. Have You or do You Intend to File a Workers' Comp Claim: <input type="checkbox"/> Yes <input type="checkbox"/> No			

C L A I M H I S T O R Y	25. Describe How and Where the Accident Occurred or Describe the Onset and Nature of Your Illness					
	26. Date You Were First Treated for Illness/Injury			27. Treated By		
				Hospital		Name Street Address City State Zip
				Doctor		Name Street Address City State Zip
28. Have You had the Same or Similar Condition Before			29. Treated By			
			Hospital		Name Street Address City State Zip	
			Doctor		Name Street Address City State Zip	

O T H E R I N C O M E	30. Describe Other Income You are Receiving					
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security (disability or retirement)	Amount	Date Began	Term.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	State Disability	\$ _____	_____	_____	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement (normal, early, or disability)	\$ _____	_____	_____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Workers' Compensation	\$ _____	_____	_____		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Group Disability Benefits	\$ _____	_____	_____		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (describe) _____	\$ _____	_____	_____		
31. Have You Applied, or do You Plan to Apply for Benefits Described Above: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Type _____		Date Application Filed _____				
Type _____		Date Application Filed _____				
32. If Your Request for Benefits is Approved, do You want Us to Withhold Amounts from each Benefit for Federal Income Tax Purposes: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Complete and Attach IRS Form W4S.						

AUTHORIZATION: I authorize any medical professional or provider, hospital, medical facility, clinic, pharmacy, Government Agency or insurance company to disclose to Blue Cross and Blue Shield of Oklahoma's (BCBSOK) claim department, reinsurers or authorized representatives information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I also authorize my employer to disclose all information needed to process my claim. This authorization expires on the date I receive notice of BCBSOK's final claim decision. I may revoke this authorization at any time, but such a revocation will have no effect on any actions taken by BCBSOK prior to receipt of the revocation. Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule. A photocopy of this authorization is as valid as the original. I understand that I should retain a copy of this authorization for my records and that my personal representative or I have a right to obtain a copy of my authorization from BCBSOK. **If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, BCBSOK has the right to deny my claim.**

Signature of Employee _____ Date _____



Name of Patient (Last) _____ (First) _____ (M.I.) _____		Date of Birth _____	*Please submit bill for records with this claim.	
H I S T O R Y	(a) When did symptoms first appear or accident happen _____	(b) Date patient ceased work because of disability _____	(c) Has patient ever had same or similar condition <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, state when and describe _____	
	(d) Is condition due to injury or sickness arising out of patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(e) Names and addresses of other treating physicians _____		
D I A G N O S I S	(a) Diagnosis (including complications) Please submit all office notes regarding this condition* _____		(b) Subjective symptoms _____	
	(c) Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings) _____			
T R E A T M E N T	(a) Date of first visit _____	(b) Date of last visit _____	(c) Frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other _____	
	(d) Nature of treatment (including surgery and medications prescribed, if any) _____			
P R O G R E S S	(a) Has patient <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed		(b) Is patient <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital confined	
	(c) Has patient been hospital confined <input type="checkbox"/> Yes <input type="checkbox"/> No Confined from _____ through _____ If, yes, give hospital name and address _____			
C A R D I A C	(a) Functional capacity (American Heart Ass'n.) <input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 3 (marked limitation) <input type="checkbox"/> Class 4 (complete limitation)		(b) Blood Pressure (last visit) _____ / _____ systolic/diastolic	
	(a) Physical impairments (*as defined in Federal Dictionary of Occupational Titles) <input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity* (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%) Remarks _____			
I M P A I R M E N T	(b) Mental Impairments (if applicable) (a) Please define "stress" as it applies to this claimant (b) What stress and problems in interpersonal relations has claimant had on job <input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks _____			
	(a) Is patient now totally disabled Patient's job: <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work: <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Date patient became disabled due to present illness _____	
P R O G N O S I S	(c) When do you expect a fundamental or marked change in the future: <input type="checkbox"/> 1 Mo <input type="checkbox"/> 1-3 Mo <input type="checkbox"/> 3-6 Mo <input type="checkbox"/> Never Applies To: <input type="checkbox"/> Patient's job <input type="checkbox"/> Other Work			
	(a) Is patient a suitable candidate for occupational rehabilitation Patient's job: <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work: <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) Can present job be modified to allow for handling with impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No	
R E H A B	(c) When could trial employment commence Date _____ <input type="checkbox"/> Full-time Patient's job: <input type="checkbox"/> Part-time _____ Patient's job: <input type="checkbox"/> Part-time			
	(Limitations, Therapy, etc.) _____			
R E M A R K S	Name (Attending Physician) (Last) _____ (First) _____ Degree _____ Telephone _____ Fax# _____			
	Address _____		City _____	State _____
Signature _____			Date _____	



DIRECT DEPOSIT AUTHORIZATION AGREEMENT

New Direct Deposit

Cancel Direct Deposit

Change to Current Direct Deposit

Please Print

Name:	Social Security Number:	Claim Number if known:
-------	-------------------------	------------------------

Fill out either the Checking Account Information Section or the Savings Account/Credit Union Information Section. You may indicate **one account only**.

Checking Account Information

Obtain this information directly from the bottom of your check or from your financial institution.

Name of Financial Institution:	
Address of Financial Institution:	
Routing Number (first number on bottom left of check):	Account Number (second number on bottom of check):

Savings Account/Credit Union Information

Obtain this information from your financial institution. The information on your deposit slip is **not** applicable for this purpose.

Name of Financial Institution:	
Address of Financial Institution:	
Routing Number (first number on bottom left of check):	Account Number (second number on bottom of check):

Authorization

I hereby authorize the company to initiate credit entries and if necessary, debit entries and adjustments for any credit entries made in error to my account, with the financial institution indicated. The financial institution is authorized by me to credit or debit my account for the amount of those entries.

This authorization is to remain in effect until the company has received written notification from me of its termination in such time and in such manner as to afford the company a reasonable opportunity to act on it.

Signature:	Date:
------------	-------

**Mail form to:
Blue Cross and Blue Shield of Oklahoma
P.O. Box 7071
Downers Grove, IL 60515**



The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading material 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 material 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: 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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 & 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.

Maryland: Any person who knowingly or willingly 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 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.

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: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars(\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

Virginia: Any person who, with the 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 may have violated the state law.



The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

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: 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.

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 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.

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.

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

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

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.

FOR APPLICATIONS ONLY:

Massachusetts: 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.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.