OneMain Solutions®

Underwritten by:
SECURIAN LIFE INSURANCE COMPANY
Administered By:
OneMain Assurance Services
P.O. Box 2548, Fort Worth, TX 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
insclaims@omf.com

Insured's Name: _____ Account/Policy # _____

Disability Claim Form

Claim # _____
(if available)

Important Information

"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."

Signature **Date**

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Disability Claim Form - Instructions

Claim # _____
(if available)

1. Read, complete, sign, and date all applicable portions of the Statement of Insured.
2. Employer must complete and sign the Employer's Section. (Not needed for continuing submissions)
3. The Physician who can verify your disability must complete the Physician's Statement.
4. Send all pages of the completed, signed claim form and any attachments to the Insurance Claims Department as shown above. Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal / medical information.

Note: Altered forms cannot be accepted.

Statement of Insured - To be completed by Insured

Name

Complete mailing address **City** **State** **Zip**

Date of birth (MM / DD / YY) **Telephone #** **Last 4 of SSN**

Email address (optional)

Self employed ☐ **Yes** ☐ **No**

Date last worked ☐☐ / ☐☐ / ☐☐ **Date unable to work due to disability** ☐☐ / ☐☐ / ☐☐

Returned to work ☐ **Yes** ☐ **No** **If Yes, date returned** ☐☐ / ☐☐ / ☐☐ ☐ **Full Duty** ☐ **Light Duty**

Describe illness or injury

Have you had the same or similar illness or injury before ☐ **Yes** ☐ **No**
If yes, when

I affirm the information I have provided herein is accurate and complete.

Signature **Date** ☐☐ / ☐☐ / ☐☐

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Disability Claim Form - Statement of Insured - To be completed by Insured

AUTHORIZATION

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) Privacy regulations, 45 CFR § 164.508, I hereby authorize any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Railroad Retirement Board, Veterans Administration or any other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to above or any of its representatives for purposes of processing this claim.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may included treatment for physical and mental illness (except for psychotherapy notes which must be requested by separate authorization), alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. Initials ☐

This authorization shall be valid for the duration of the claim. I have the right to revoke this authorization by providing a signed and dated, written notice to the insurance company above. Once this authorization is revoked, protected health information subject to this authorization will not be used or disclosed except to the extent that this authorization has already been relied upon. I understand that in executing this authorization the information disclosed may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance and Portability and Accountability Act (HIPPA). I understand that I have the right to retain a copy of this authorization and to inspect and receive any information disclosed under its terms. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature _____ **Date** ☐☐ / ☐☐ / ☐☐

Statement of Employer - To be Completed by Most Recent Employer

Date last worked ☐☐ / ☐☐ / ☐☐

On last work day, did employee work
☐ **Full Day** ☐ **Partial Day** ☐ **Not at all**

Date unable to work due to disability ☐☐ / ☐☐ / ☐☐

Date employee returned to work ☐☐ / ☐☐ / ☐☐

Original date of hire ☐☐ / ☐☐ / ☐☐

If terminated, date terminated ☐☐ / ☐☐ / ☐☐

Signature of Individual completing **Date**

Printed name **Title**

Company name

Complete mailing address **City** **State** **Zip**

Telephone # **Fax #**

Email address

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Insured's Name: _____ Account/Policy # _____

Claim # _____
(if available)

Disability Claim Form - Statement of Attending Physician - To be Completed by Attending Physician

Completed without expense to the Insurance company.

Patient unable to work due to disability ☐☐ / ☐☐ / ☐☐ **Through** ☐☐ / ☐☐ / ☐☐

Initial date of treatment ☐☐ / ☐☐ / ☐☐ **All subsequent treatment dates** _____

Frequency of visits ☐ **Weekly** ☐ **Monthly** ☐ **Other**

Primary diagnosis **ICD code(s)**

Contributing cause/complications of disability

Surgical or obstetrical procedures and dates

If pregnancy related, provide the estimated date of delivery and list any complications

If hospitalized, dates of hospitalization

Name of Hospital

Has patient ever had the same or similar condition ☐ **Yes** ☐ **No** **If yes, when**

Date symptoms first appeared or accident occurred _____

Is patient
☐ **"Totally Disabled" (Unable to perform any duties of his/her occupation)**
☐ **"Partially Disabled" (Can perform some of his/her duties)**

Approximate date patient will be able to return to work _____ ☐ **2-5 months** ☐ **6-12 months** ☐ **Over 12 months** ☐ **Never returning**

Name of referring physician, if any **Date of referral**

Referring physician's complete mailing address **City** **State** **Zip**

Signature of attending physician **Date**

Printed name

Complete mailing address **City** **State** **Zip**

Telephone # **Fax #**

Email address