M.S.E.A INCOME PROTECTION PLAN & TRUST

65 State Street, Augusta, Maine 04330

(207) 622-3151 / 1-800-452-8794 / (207) 623-7649 (TDD) / (207) 621-1475 (FAX)

PRELIMINARY STATEMENT OF DISABILITY

Section 1 – Employee Information – Please Print Clearly

Name: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone #: (H) _____ (W) _____ E-Mail _____

Last Date Worked: _____ Dept: _____ Occupation: _____

Date Injury/Illness Began: _____ Date of First Medical Treatment: _____

Name/Phone of Medical/Mental Health Provider: _____

Describe Injury/Illness: _____

If injury, please explain where, when, and how you were injured: _____

Have you filed a Worker's Compensation claim for this condition? ___ Yes ___ No

Have you ever served in the Military? ___ Yes ___ No

I hereby certify that I have answered all questions truthfully and to the best of my knowledge. I have signed the medical release and subrogation agreements on the reverse side of this form.

Employee Signature: _____ Date: _____

Section 2 – Attending Medical/Mental Health Provider Statement

Diagnosis (Include ICD 10 Codes): _____

_____

List Surgical Procedures, if any: _____

If pregnancy, please give Estimated Date of Delivery: ___/___/___

Date Injury/Illness Occurred: ___/___/___ Date Patient First Consulted You: ___/___/___

Dates of Treatment: (Office)_____ (Hospital) _____

Is Patient Totally Disabled from Performing His/Her Job? ___ Yes ___ No

Is Condition Due to Patient's Employment? ___ Yes ___ No

Is Patient Still Under Your Care for Condition? ___ Yes ___ No Date of Next Appt: ___/___/___

Dates of Continuous Total Disability: From ___/___/___ Through ___/___/___ *

* If unknown at this time, please estimate approximate length of disability period _____

Please type or print

Provider's Name: _____ Telephone #: _____

Address: _____ City _____ State _____ Zip _____

Provider's Signature: _____ **Date:** _____

Section 3 – MSEA Income Protection Plan – Office Use Only

Department: _____ Social Security #: _____ Payroll: _____

Date Employed: _____ Date Joined IP: _____ Open Enrollment? ___ Yes ___ No

Eff Date of Last Change: _____ Monthly Benefit: $_____ OE Inc? ___ Yes ___ No

IPPT Personnel Signature _____ Date _____

Please return the completed form to the MSEA Income Protection Plan at the address above. Incomplete forms will be returned for completion and will delay processing of benefits.

NAME: _____ Soc Sec #: _____

Release of Information

I authorize the MSEA Income Protection Plan & Trust or its designees, all health providers, third party payers, utilization review agencies, my employer, my attorney, and state or federal agencies to exchange all demographic, medical, mental health, AIDS and HIV, and substance abuse information necessary for claims processing, clinical studies, care management, plan administration, benefit determination or resolution of subrogation and workers' compensation issues. I understand any such information will be used only after issuance of coverage and will have no effect on determination of eligibility to enroll.

I give this consent for myself and my successors, heirs and assigns. (I understand that failure to sign this unmodified authorization may be basis for benefit denial.) I understand I am entitled to receive a copy of this authorization. I further understand that this authorization will remain in effect until coverage under this plan ends or I give written notice to the MSEA Income Protection Plan that I want to revoke this authorization. I understand that revocation of this authorization may be a basis for denying benefits.

I also agree a photostatic copy of said authorization shall be as valid as the original.

_____/_____/_____ _____
Date Signature of Plan Participant

_____
Witness' Signature

A. Workers' Compensation Agreement

I, _____, have read and understand the terms outlined in the Workers' Compensation clause of the General Accident and Sickness Provisions section of the Summary Plan Description. In the event any evidence is produced from any source to support a claim for Workers' Compensation benefits, I agree to follow said terms outlined in the Summary Plan Description. I understand that failure to supply required information may result in suspension of benefit payments until the information is provided.

B. Subrogation Reimbursement Agreement

I, _____, agree that, by accepting benefits under the MSEA Income Protection Plan for an injury or sickness arising out of or in the course of employment, I will reimburse the Contract Administrator the total amount of Income Protection Plan benefits I receive in the event my workers' compensation claim is approved or validated. My claim for workers' compensation will be deemed to have been approved if I receive any monetary amount or non-monetary compensation arising out of my work-related injury or sickness, including, but not limited to, re-instatement of leave time, payment of medical expenses (in whole or in part), or the receipt of any other benefit, whether by judgment, decree, settlement or otherwise. The recipient of such recovery may be me, my heirs, or any vendor being reimbursed for services performed or expenses incurred associated with the injury or sickness.

I also authorize any responsible third party or their insurer, workers' compensation carrier, or the representing attorney to reimburse the MSEA Income Protection Plan directly for benefits I receive as an alternative to reimbursing me, but only to the extent of any benefits received by me, my dependents or my heirs under the Income Protection Plan. In the event that I violate or breach the terms of this Subrogation Agreement, I agree to pay all costs and expenses, including reasonable attorneys' fees, for the enforcement of this Agreement by the MSEA Income Protection Plan.

_____/_____/_____ _____
Date Signature of Plan Participant

_____
Witness' Signature

Designated Representative (Complete this section to assign someone other than yourself, i.e. spouse, child, parent, etc., the right to discuss any and all aspects of your claim with MSEA Income Protection Plan representatives.)

Name of Representative: _____ Relationship: _____

Telephone #: _____

_____/_____/_____ _____
Date Signature of Plan Participant

_____
Witness' Signature

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INSTRUCTIONS AND INFORMATION FOR FILING A CLAIM

1) Complete Section 1 of the claim form. Be sure to sign and date the form.

2) Complete the back of the form. The Release of Information allows us to obtain the required information to process your claim. The Workers' Compensation section must be signed even if your disability doesn't appear to be work related. The Designated Representative section is voluntary but necessary if anyone other than yourself will be calling about your claim.

3) Have your attending medical or mental health provider complete Section 2 of the claim form.
** If you have seen more than one provider, please include a copy of any doctor's note that verifies the period of disability.

4) When the claim form is complete, return it to the MSEA Income Protection Plan at the address on the form.
Incomplete information on your claim form could result in a delay of benefit payments.
Please do not return the form until you are actually out of work.

5) You will be required to submit additional medical information on a monthly basis.

6) When you are released to return to work, call the Income Protection Dept at MSEA and mail a copy of your doctor's note.

NOTE

If you exhaust your sick leave, vacation time, etc. and/or you are no longer on payroll, your MSEA dues and Income Protection premiums will be deducted from your benefit check. In the event these amounts are not withheld from your benefit check, you will be billed directly.

IMPORTANT INFORMATION

Retirement:

If you are filing an Income Protection claim and you retire either due to your disability or retire while filing an Income Protection claim, the Income Protection Plan will pay up to six (6) full months of benefits after satisfying a fourteen (14) day waiting period. If you are disabled beyond that six month period, benefits will be suspended until a decision is made on the retirement request. If the retirement application is accepted, the Income Protection Plan will only make payments of the 7th through 12th months if the retirement benefit is less than the Income Protection benefits. If the retirement application is denied, the Income Protection Plan will pay the benefits in full for the 7th through 12th months or until the end of the disability, whichever is less. In the event that Income Protection benefits have been paid beyond the 6th month before the application for retirement is filed, benefits will immediately be suspended and up to 100% of the benefits paid for the 7th through 12th months may become reimbursable to the Income Protection Plan upon acceptance of retirement.

Workers' Compensation:

You may file for Income Protection benefits if your claim for Workers' Compensation benefits has been controverted and you are awaiting a final decision. Prior to receiving benefits, you must sign an agreement to reimburse the Income Protection Plan for all benefits advanced to you if you are found eligible for any Workers' Compensation benefits and you must supply the Income Protection Plan with a copy of the Notice of Controversy you received from Workers' Compensation. In addition, you will be required to supply the Plan with written monthly updates on your Workers' Compensation claim including copies of any letters received from Workers' Compensation.

Mental Health, Nervous, & Stress Conditions:

Disabilities due to these conditions must be certified by a licensed mental health professional and your disability claim must show that you are receiving active treatment for your condition.