UTBA Disability Claim Form

File claims using the Online Service Center (OSC) for faster payments, claim status updates, direct deposit and more.
Sign up or log in now!

Instructions for the Insured

Please fill out the Statement of Insured as it pertains to your claim:

- If you are filing an **initial disability** claim, fill out Sections A to F and also Section H.
- If you are filing a claim for **continuing disability**, fill out Sections A to E and then Sections G to H.
- It is not mandatory to complete Section I, however doing so can help avoid delays in requesting further information needed for your claim.
- Ensure the following documents are provided along with your completed Statement of Insured for benefit consideration:
    - The Status of Trucker Statement, which must be filled out by an authorized individual from the organization through which you are enrolled in benefits or UTBA, is required for an **initial disability** claim.
        - Please contact UTBA for assistance in completing the Status of Trucker Statement:

Group Contacts	Kaylene Sutherland-Smith
	Royalina Leone
Telephone Number:	877-472-5541
Hours of Operation:	Monday – Thursday: 7:30 a.m. – 4:00 p.m. CT
	Friday: 7:30 a.m. – 3:00 p.m. CT

    - Your treating physician should complete the Attending Physician's Statement.
    - If your disability claim is related to a work injury or illness, include a Worker's Compensation Award or Denial Letter.
    - Include an Award or Denial Letter for any other sources of income that are deductible.
- Your signature is necessary in the Acknowledgement Section of the Statement of Insured for benefit consideration.

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STATEMENT OF INSURED

Section A - About the Insured

First Name	MI	Last Name	Suffix

Date of Birth	Social Security Number **or** Policy Number(s)

Address	City	State	Zip Code

Home Phone Number	Cell Phone Number	E-mail Address

Section B – Workers' Compensation Details

What is the status of your Workers' Compensation claim or appeal?

☐ Not applicable/Will not file ☐ Not yet filed but plan to file ☐ Pending ☐ Approved ☐ Denied

Section C – Employment Details

Date last worked in any job: _____ Has your employment terminated? ☐ Yes ☐ No

Date you returned or expect to return to work Part-time _____ Full-time _____

Section D – Sources of Income

Please provide information for any additional income sources listed below that either you or your dependents have received or could receive. Specify the start and end dates for the income from these sources, if relevant. In cases where no income is derived from a listed source, enter $0.00 in the corresponding amount field.

Income Source	Amount	Frequency	Begin Date	End Date	Organization Name	Organization Contact #:
Other group disability income						
Retirement Income						
Social Security Income						
State Disability						
Unemployment Compensation						
Sick Leave or Wage Continuation						
V.A. Benefits						

Section E – Federal Income Tax Withholding

Specify the dollar amount, if any, to be withheld for federal taxes if your claim for disability benefits is approved.

☐ Do not withhold federal taxes or amount: _____ (minimum amount to withhold is $87.00)

Section F – Initial Disability Details

Is the disability due to a: ☐ sickness ☐ accidental injury OR ☐ pregnancy?

If sickness, what medical condition(s) is causing the disability? _____

If you've previously had or been treated for the same or similar condition, please explain:

_____

If accident, describe the cause and details of the accident:

_____

If pregnancy, date of delivery: _____ Delivery method: ☐ vaginal OR ☐ cesarean?

List the contact details of all treating physicians (attach additional list if necessary):

Physician's First and Last Name _____ Physician's Contact Number _____

Physician's First and Last Name		Physician's Contact Number	
Physician's First and Last Name		Physician's Contact Number	

Section G – Continuing Disability Details

List your current daily activities:

List any other medical conditions or injuries that have occurred since your last report

List the contact details of any new physicians since your last report (attach additional list if necessary)

Physician's First Name	Physician's Last Name	Physician's Office Contact Number
Physician's First Name	Physician's Last Name	Physician's Office Contact Number

Acknowledgement - Your signature is required for benefit consideration

I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included in this claim form.

Signature of Insured: Date Signed:

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Section H – Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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.

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, District of Columbia, Louisiana, Rhode Island and 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.

For your protection **California** law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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, Idaho and 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.

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.

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.

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.

Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland - 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.

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.

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.

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 by 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.

For your protection **Texas** 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.

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Section I - Authorization to Request Information Including Protected Health Information

The purpose of this form is to allow American Public Life Insurance Company (APL), or business partners acting on behalf of APL in the administration of APL products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, APL may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing APL who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. APL will only disclose any data collected pursuant to this authorization as necessary for legitimate business purposes, and only to the extent allowed by law.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which I may have been treated.

I understand APL may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or an inability to pay benefits under my policy if my failure to sign results in APL not having enough information to process my benefits. I understand I may revoke this authorization at any time by writing to APL, P.O. Box 248950, Oklahoma City, OK 73124-8950 or by calling 800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: APL has acted in reliance on the authorization; or the law provides APL with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. In addition to the types of information described above, I also authorize APL to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to APL.

For health insurance coverage, this authorization will expire 24 months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire 24 months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

APL Policy Number	Printed Name of Patient	Patient's Date of Birth

Signature (*Patient*) or Personal Representative (*if applicable*)	Date Signed

Relationship of Personal Representative to Patient (if applicable)
If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

UTBA Disability Claim Form

ATTENDING PHYSICIAN'S STATEMENT

Instructions for the Physician

- Complete the Attending Physician's Statement (Sections J1 through J4) as applicable to your Patient.
- Send the signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

J1 – Patient Information

First Name	MI	Last Name	Suffix

Date of Birth	Social Security Number **or** Policy Number(s)

J2 – About the Diagnosis and History of Diagnosis

List the ICD codes which correspond to the diagnosis resulting in patient's current disability (including complications):

List any complications related to the patient's condition(s)

Date symptoms first appeared/accident occurred: Is disability work related? ☐ Yes ☐ No

Has patient had same/similar diagnosis? ☐ Yes ☐ No/Unknown If yes, date of onset?

If the patient was referred to you, provide the contact details of the referring physician:

Referring Physician's Name: Referring Physician's Contact Number:

J3 – Extent of Disability

Date disability began: ☐ Actual OR ☐ Anticipated RTW Date:

In how many months do you expect a fundamental change in patient's condition?

☐ Less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Never

Is patient able to work in any occupation while disabled? ☐ Yes ☐ No

Select the most appropriate class of physical impairments **As defined in Federal Dictionary of Occupational Titles*

☐ Class 1 – No limitation capable of heavy work. No restrictions. (0-10%)*

☐ Class 2 – Medium manual activity. (15-30%)*

☐ Class 3 – Slight limitation of functional capacity; capable of clerical/administrative sedentary activity. (35-55%)*

☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. (60-70%)*

☐ Class 5 – Severe limitation of functional capacity; incapable of minimum sedentary activity. (75-100%)*

List any restrictions and functional limitations caused by this disability

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J4 – Treatment

Date first treated for condition: | Date of most recent treatment:

Frequency of Treatment: ☐ Weekly ☐ Monthly ☐ Other (describe):

If patient is still under your care, date of next appointment:

If patient is no longer under your care: date released: | Reason:

If patient was referred to another physician, provide name and phone number of the physician to which the patient was referred:

Physician's First and Last Name: | Contact Number:

Attending Physician Information, Acknowledgement and Signature

Physician's First Name	Physician's Last Name	Degree	Specialty

Physician's Office Location	City	State	Zip

Physician's Office Contact Number	Physician's Office Fax Number	Physician's NPI	Physician's IRS ID Number

This form documents my verification of the above-named individual's current condition. I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I understand that I may be asked periodically for updates related to the individual's condition and treatment plan.

Printed Name of Person Completing Form	Title	Contact Number

Authorized Signature | Date Signed

UTBA Disability Claim Form

Status of Trucker Statement

Instructions for the Employer/Organization

The Status of Trucker Statement is required for benefit consideration of a claim filed on behalf of an insured enrolled in coverage under your organization.

- This form must be completed by the Insured's organization or UTBA. Please refer to instruction page for UTBA's contact information.
- All sections of the form must be completed as applicable to the Insured for whom the claim is being filed.
- Send the signed form and supporting documentation to the address or fax number listed above.

K1 – Insured's Information

First Name	MI	Last Name	Suffix

Date of Birth	Social Security Number **or** Policy Number(s)

K2 – Employment/Work Status

Date Contracted:

Date last worked | Has the insured been terminated? ☐ Yes ☐ No

Indicate the typical number of hours per week that the insured works for your organization:

If insured is unable to work due to a work-related injury or illness, provide the following details for the Worker's Compensation Carrier:

☐ Not applicable Carrier Name: Carrier Contact Number:

K3 – Salary Information

1099 Amount reported for most recent Calendar Year:

List the insured's annual salary amount

List the insured's salary over the 12-month period immediately preceding the date last worked:

Complete the details for the other sources of income identified below that the insured is receiving or is eligible to receive. If the insured is not eligible to receive these benefits, list $0.00 in the amount field.

Income Source	Amount	Frequency	Begin Date	End Date	Company Name	Contact Number
Other Group Disability						
Salary Continuation						
Sick Leave						
PTO/PPT						
Retirement/Pension						
Other (Bonus, etc.)						

K4 – Premium Information

Are premium contributions paid by the insured on a pre-tax or post-tax basis? ☐ Pre-tax ☐ Post-tax

What percentage, if any, of disability premiums are paid by your organization?

Employer's/Organization's Information, Acknowledgement and Signature

This form documents verification of the above-named individual's current employment status with the Organization shown below. I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I understand that I may be asked periodically for updates related to the individual's employment status.

Name of Trucking Firm	Trucking Firm Contact Number:	Trucking Firm Fax Number:

Printed Name of Person Completing Form	Title	Contact Number

Authorized Signature		Date Signed	