WEA trust
P.O. Box 21538 | Eagan, Minnesota 55121-5038
800.279.4000 WEAtrust.com

Claim Form for Verification of Disability for Waiver of Premium Or Continuation of Insurance Coverage

Instructions

This form or other similar written notice of claim must be submitted **within 90 days** of the ***onset*** of your alleged disability. If you have any questions, call WEA Trust at 608.276.4000 or 800.279.4000. Please **print** (use blue or black ink) and return the completed claim form **with medical records** to the WEA Trust.

This form consists of three sections. Each section must be completed after the onset of your alleged disability. Return the entire form and medical records to WEA Trust, P.O. Box 21538, Eagan, MN 55121-5038

Section 1: Employer Information Section

The employer must:

- Complete this section in full.
- Sign and date this section.
- **Attach a copy of the current job description to this form.**

Section 2: Claimant Information Section

The claimant must:

- Complete this section in full.
- Sign and date this section and include a current address and telephone number.
- Have your employer and treating physician complete in full the appropriate sections of this form.
- Review all four sections to make sure they are completed in full and that all questions are answered prior to returning the form to us.
- **Attach medical records to this form that document your condition. ***

Section 3: Attending Physician's Section

Under the terms of our policies, this form can only be completed by one of the following health professionals: M.D., D.O., D.S.C., D.P.M., O.D., D.C., D.D.S., D.M.D. The attending physician must:

- Complete this section in full; each space must contain a response. A vague or incomplete response will result in additional correspondence and cause a delay in the processing of the claim.
- Sign and date this section.
- **Attach medical records to this form that document the patient's condition. ***

*** According to the express terms of the health and long term care policies, we do not reimburse for the cost of medical records. Any charges for the release of this information are the responsibility of the claimant and should be billed directly to him or her.**

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Employer Information Section

Employee Name:	Subscriber No.:
1. Employee's current occupation: **(Please attach copy of current job description)**	2. Date employment began:
3. Last date worked:	4. First date unable to work:

5. Type of employment: ☐ Part-time ☐ Full Time ☐ Year-round ☐ Other (including academic year)

6. Current Employment status (circle one): Active Terminated Resigned Retired	7. Effective date of this employment status:

8. Employee returned, or is expected to return, to work on a: ☐ Part-time basis on: ____________ ☐ Full-time basis on: ____________

9. Please provide name and telephone number of employee's direct supervisor:

10. Do you provide long term disability coverage for this employee through another carrier? ☐ Yes ☐ No
If yes, indicate name and telephone number of the long term disability carrier:

Has an LTD claim been filed? ☐ Yes ☐ No
Have LTD benefits been approved? ☐ Yes ☐ No
(Please attach copy of approval/denial notice)

11. Has a worker's compensation claim been filed? ☐ Yes ☐ No
If yes, indicate worker's compensation claim number and weekly benefit:

Have worker's compensation benefits been awarded? ☐ Yes ☐ No
(Please attach copy of approval/denial notice)

12. Indicate name, address, and telephone number of worker's compensation insurer:

I affirm the above information is true and complete to the best of my knowledge.

Employer's name and address: ____

____

Name of authorized representative **(Please print or type)**: ____________________

Title: ____________ Phone: ____________ Ext.: ________

____________________________ **Authorized Representative's Signature**

____________ **Date**

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(To be completed and signed after the onset of alleged disability.)

Claimant Information Section

Claimant's Name:		Home Phone No.:
Address:		Date of Birth:
		Marital Status: S M W D **(Circle One)**
Subscriber No.:	Occupation:	Male / Female **(Circle One)**

1. Medical condition/diagnosis:

2. How does your condition limit your physical or mental ability to perform the specific requirements of your job? **(Attach separate sheet if necessary)**

3. Date of accident or date symptoms began:	4. Date first treated for this condition:
5. Last date worked:	6. First date unable to work:

7. Date you expect to return to work:

8. Are you or were you confined to a hospital for this condition: ☐ Yes ☐ No
   If yes, give name and address of hospital:

   Admission Date: Discharge Date:

9. Please list name, address, and telephone number of **ALL** physicians involved in your treatment:
   (Attach separate sheet if necessary)

10. Is the condition/injury the result of an accident? ☐ Yes ☐ No
    If yes, please provide information regarding how, when, and where accident occurred: **(Attach separate sheet if necessary)**

11. Did the condition/injury arise out of your employment? ☐ Yes ☐ No
    If yes, was your employer notified? ☐ Yes ☐ No
    Did you file a worker's compensation claim? ☐ Yes ☐ No
    Were benefits awarded? ☐ Yes ☐ No

12. Do you have long term disability coverage with another carrier? ☐ Yes ☐ No
    If yes, have you filed a claim with that carrier? ☐ Yes ☐ No
    Have you been awarded benefits? ☐ Yes ☐ No
    (Please attach a copy of any approval or denial letter)

13. Have you applied for or are you receiving Social Security Disability Insurance benefits? ☐ Yes ☐ No

14. Have you applied for or are you on Medicare? ☐ Yes ☐ No
    If yes, please attach a copy of your Medicare card.

The above information is true and complete to the best of my knowledge.

Claimant's Signature	**Date**

(If claimant is unable to sign, state reason and specify signer's relationship to the claimant.)

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Attending Physician's Section

Patient Name:	Patient I.D. No.:
Subscriber No.:	Date of Birth:

1. Current diagnosis **(Please attach relevant medical records):**
   - ICD-10 code(s):
   - Surgery performed:
   - Date(s) of surgery:

2. Patient's current symptoms:

3. List all functional limitations caused by the patient's condition or symptoms:

4. Are the limitations temporary or permanent? ☐ Temporary ☐ Permanent
   Specify the date on which these limitations began:

5. Patient's prognosis:
   Do you expect full or partial recovery? ☐ Full ☐ Partial Date you expect recovery: ____________________

6. When did the patient first consult you for this condition?

7. Is the patient still under your care for this condition?
   ☐ Yes ☐ No
   If no, indicate discharge date:

8. Please give date(s) of all hospitalization(s) related to this condition:
   From: To:

I affirm the above information is true and complete to the best of my knowledge.

Physician's name **(Please print or type)**: ____________________

Degree: ☐ M.D. ☐ Other: ____________________ Specialty: ____________________

Name of Clinic: ____________________ Address: ____________________

City: ____________________ State: __________ Zip Code: ______________ Phone No.: ______________

____________________ ____________________
Attending Physician's Signature **Date**

NOTE: Please attach all medical records documenting patient's condition.