aetna®

STD Disability Employee Request

Mail this completed form to:

Aetna Voluntary Plans
PO Box 14079
Lexington, KY 40512-4079

Fax: 1-859-455-8650
Phone: 1-866-292-3374

Internal Use	
Office Key Code	128

- Complete this form when your disability absence goes beyond your plans waiting period.
- Ask your physician to complete the Attending Physician's Statement on the reverse side.
- Return completed form to employer.

1. Employer Information

Name	Control Number
Address (include ZIP Code)	

2. Employee Information

Social Security Number	Name		Birthdate (MM/DD/YYYY)
Address (include ZIP Code)		Daytime Telephone Number ( )	Has your employment terminated and/or are you currently on layoff? ☐ No ☐ Yes
Basic Income Weekly $ _____ Monthly $ _____	Description of job duties:	Are you currently employed elsewhere? ☐ No ☐ Yes	Gender ☐ Male ☐ Female

3. Claim Information

Is absence work related?	Is claim related to an accident?
☐ No ☐ Yes	☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm
Nature of illness or injury for which claim is being made. If injury, please describe how, when and where.	
Expected return to work date _____	

4. Release

To all physicians, providers, practitioners, hospitals, vocational rehabilitation counselor, and workers' compensation insurance carrriers ("Provider"):

You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient. This information will be used to evaluate, analyze, manage and/or administer claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. I understand that Aetna and the entities mentioned above may further disclose this information if required under law. This consent is subject to revocation at any time except to the extent that the Provider has already acted in reliance of the original authorization.

Authorized Person's Signature	Date (MM/DD/YYYY)

Name	Social Security Number

5. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Alabama Residents: 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. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** 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. **Attention California Residents:** ***For your protection California law requires notice of the following to appear on this form:*** *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.* **Attention Colorado Residents:** 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. **Attention Florida Residents:** 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. **Attention Kansas and Missouri Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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. **Attention Louisiana Residents:** 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 is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** 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 denial of insurance benefits. **Attention Maryland Residents:** 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. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** 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. **Attention Oklahoma Residents:** 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. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** 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. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** 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.

Employee's Signature	Date (MM/DD/YYYY)

Name	Social Security Number

Note: Aetna may request additional statements as necessary

Attending Physician's Statement

The patient is responsible for any expense incurred for completion of this form.

Patient's Name		Patient's Birthdate (MM/DD/YYYY)
Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)	Date first seen and treated by you for this condition	If patient has had similar illness or injury, give dates
Date total disability From ___/___/_____ Through ___/___/_____ MM DD YYYY MM DD Y YYY	Date partial disability From ___/___/_____ Through ___/___/_____ MM DD YYYY MM DD Y YYY	Date patient able to return to work (MM/DD/YYYY) (If unknown, give estimate)
Date if next visit ___/___/_____ MM DD YYYY	For services related to hospitalization give hospitalization dates Admitted ___/___/_____ Discharged ___/___/_____ MM DD YYYY MM DD YYYY	

Diagnosis or nature of illness or injury (please indicate primary and secondary)

1. _____
2. _____
3. _____
4. If disability is due to pregnancy, the expected delivery date is ___/___/_____ MM DD YYYY

List current medications and dosages

Procedures and/or Medical Services related to this disability

Date of Service MM DD YYYY	Description of Service	Type of Service †	Diagnosis Code ††
/ /			
/ /			
/ /			

Limitations

(a) What are patient's present capabilities? _____

(b) What are present limitations (physical and/or mental)? _____

(c) What restrictions are placed on patient? _____

(d) Name of referring physician _____ Date of next visit ___/___/_____ MM DD YYYY

Physical Impairment – As defined in Federal Dictionary of Occupational Titles

- ☐ Class 1 – No limitations of functional capacity; capable of heavy work.* No restrictions. (0 – 10%)
- ☐ Class 2 – Medium manual activity.* (13 – 30 %)
- ☐ Class 3 – Slight limitation of functional capacity; capable of light work.* (35 – 50%)
- ☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 – 70%)
- ☐ Class 5 – Severe limitations of functional capacity; incapable of minimal (sedentary*) activity. (75 - 100%)
- ☐ Remarks: _____

Mental/Nervous Impairment (if applicable)

What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitation)
- ☐ Class 2 - Patient is able to function in most stress situations and engage in interpersonal relations (slight limitation)
- ☐ Class 3 - Patient is able to engage in stress situations and engage in only limited interpersonal relations (moderate limitation)
- ☐ Class 4 - Patient is unable to engage in stress situations and engage in interpersonal relations (marked limited)
- ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitation)
- ☐ Remarks: _____

Physician's Signature	Date (MM/DD/YYYY)
Physician's Name & Address (include ZIP Code)	Telephone Number ( ) Fax Number ( )