



STATEMENT OF RECOVERY OR RETURN TO WORK

DISABILITY INCOME CLAIM INSTRUCTIONS

(PLEASE DETACH THIS NOTICE BEFORE MAILING AND KEEP FOR FUTURE REFERENCE)

Please answer all questions on the Member Statement on your Disability Income claim form. Date and sign both the Members Statement, the Authorization for Release of Information on Page 3 and have your Medical Provider complete the rest of the form. Please see that the completed form is returned to:

Pearl Carroll & Associates LLC
PO Box 1519
Latham, NY 12110

If you recover or return to work, please notify New York Life immediately by completing and mailing the statement below to the above address.

If you have any questions concerning your request for Disability Income benefits, you may call the Office of the Administrator at 1-800-697-2732. Our fax number is 518-640-8105.

Name: \_\_\_\_\_

Residential Address: \_\_\_\_\_
\_\_\_\_\_

Social Security No.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy G-11628

I recovered: [ ] I returned to work [ ] on \_\_\_\_/\_\_\_\_/\_\_\_\_
Mo. Day Year

Other: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Email Address: \_\_\_\_\_



CSEA MEMBER'S DISABILITY INCOME FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_ Female  Male

Residential Address: \_\_\_\_\_  
(No.) (Street) (City or Town) (State) (Zip Code)

Telephone No.: Home: ( ) \_\_\_\_\_ Employer ( ) \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Normal Number of Hours Worked  
Per Week: \_\_\_\_\_

Employer's Street Address: \_\_\_\_\_  
(No.) (Street) (City or Town) (State) (Zip Code)

Email Address: \_\_\_\_\_

What is the nature of your disability? \_\_\_\_\_

Is disability work related? Yes  No  If yes, please attach an Employee Accident Report.

Is disability due to an Injury? Yes  No  If "Yes", when? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

Where did it happen? \_\_\_\_\_

How did it happen? \_\_\_\_\_

**\*\*If disability is due to a Motor Vehicle Accident, please attach MV-104A Police Report\*\***

**\*\* If treated in hospital or Urgent Care Center, please submit attach your discharge papers\*\***

Date first treated for this disability: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

Date First Unable to Work: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Last Worked: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year Mo. Day Year

Have you attempted to return to your occupation since the date disability began? (If so, give details)

\_\_\_\_\_

If returned to work or recovered, give date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Returned to work: Full Time:   
Mo. Day Year Part Time:

If not returned, when do you expect to? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year If Part Time, # of hours per day \_\_\_\_\_

**NAMES AND ADDRESSES OF FIRST PROVIDER CONSULTED AND OTHER PROVIDERS SEEN FOR TREATMENT.**

\_\_\_\_\_  
(Name) (Address) (Phone Number) (TREATED FROM \_\_\_\_\_ TO \_\_\_\_\_)

\_\_\_\_\_  
(Name) (Address) (Phone Number) (TREATED FROM \_\_\_\_\_ TO \_\_\_\_\_)

Member Name; \_\_\_\_\_ Please state your occupation: \_\_\_\_\_

**\*\*Please attach a copy of your official job description.**

Please fully describe all the duties of your occupation at the time you stopped working including the percentage of time spent on each activity: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your daily activities since disability began? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you receiving or will you be eligible to receive benefits from: Social Security Disability? Yes  No   
Salary or other Compensation? Yes  No   
Pension Plan? Yes  No   
Another Group Insurance Plan? Yes  No   
Individual Disability Income Policy? Yes  No

If "Yes" insert policy number, claim number and address of insurance company or organization providing such benefits and amount of payment.

Policy No. Claim No. Name and Address Amount of Payment

Policy No. Claim No. Name and Address Amount of Payment

I declare that the answers on Page 1 and Page 2 of this form are complete and true to the best of my knowledge and belief. I also agree that I will advise the New York Life Insurance Company of my return to any type of work and that I will return any payments to which I am not entitled by reason of my return to work or termination of my disability.

**PLEASE NOTE:** 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

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO DAY YEAR

Member's Signature \_\_\_\_\_

The Member or someone on his/her behalf must sign here and on the Authorization for Release of Information Form.

Please see that the completed form is returned to:

**Pearl Carroll & Associates LLC**  
PO Box 1519  
Latham, NY 12110  
Fax # 518-640-8105



**Authorization for Release of Information**

**Release from:** \_\_\_\_\_  
\_\_\_\_\_

I authorize release to New York Life Insurance Company or their representative, Pearl Carroll & Associates LLC, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying New York Life in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

|                            |                                   |
|----------------------------|-----------------------------------|
| _____                      | _____                             |
| <b>Patient's Signature</b> | <b>Date</b>                       |
| _____                      | <b>Social Security No.:</b> _____ |
| <b>Print Name</b>          |                                   |
| _____                      | _____                             |
| Address                    | Phone Number                      |

**Email Address:** \_\_\_\_\_

**Release to:** Chart Access, Inc. 1010 Lamar, Suite 300 Houston, TX 77002

**Please see that the completed form is returned to:**

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PO Box 1519  
Latham, NY 12110  
Fax # 518-640-8105**

**MEDICAL PROVIDER'S STATEMENT**

*(The patient is responsible for the completion of this form without expense to the Company)*

**Notice to Provider:** Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to his or her specific contract with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. **PATIENT'S NAME:** \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(First) (Middle) (Last) MM DD YYYY*

2. **CURRENT MEDICAL CONDITION(s):**

PRIMARY DIAGNOSIS: \_\_\_\_\_ ICD-9 CM CODE: \_\_\_\_\_

SECONDARY DIAGNOSIS: \_\_\_\_\_ ICD-9 CM CODE: \_\_\_\_\_

3. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(Month) (Day) (Year)*

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(Month) (Day) (Year)*

5. DATE YOU LAST TREATED THE PATIENT: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(Month) (Day) (Year)*

6. IS THIS CONDITION RELATED TO PATIENT'S EMPLOYMENT? YES  NO

7. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? YES  NO   
*(If "Yes", please provide the name and address of that practitioner):* \_\_\_\_\_

8. OBJECTIVE FINDINGS *(Include x-rays, lab results and clinical findings. If pregnancy, also give LMP and EDC):* \_\_\_\_\_

9. HAS PATIENT BEEN HOSPITALIZED? YES  NO  *(If "YES", provide reason, hospital name and dates of confinement):* \_\_\_\_\_

10. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED: *(Include surgery and medications prescribed if applicable)* \_\_\_\_\_

11. HAVE YOU REFERRED THE PATIENT TO ANOTHER PRACTITIONER? YES  NO  *(If "Yes", please provide the name and address of all applicable physicians or practitioners):* \_\_\_\_\_

12. IN YOUR OPINION IS THE PATIENT ABLE TO WORK AT THIS TIME? YES  NO   
IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(Month) (Day) (Year)*

13. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES  NO  *(If "Yes", please describe)* \_\_\_\_\_

Patient's Name \_\_\_\_\_

SSN# \_\_\_\_\_

14. **BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:**

a) THE PATIENT WAS TOTALLY DISABLED FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_  
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

b) THE PATIENT WAS PARTIALLY DISABLED FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_  
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

15. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO HIS OR HER MEDICAL CONDITION (If none, indicate "NONE"): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES  NO

IF "YES" DATE RELEASED FROM YOUR CARE:  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(MO) (DAY) (YEAR)

IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION:  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(MO) (DAY) (YEAR)

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**MEDICAL PROVIDER'S DECLARATION AND SIGNATURE**

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

\_\_\_\_\_  
PROVIDER'S NAME (PLEASE PRINT)                      Specialty                      ( ) TELEPHONE NUMBER

\_\_\_\_\_  
STREET ADDRESS                      CITY                      STATE                      ZIP CODE

\_\_\_\_\_  
PROVIDER'S SIGNATURE                      DATE SIGNED

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