



**Calhoun County**

**STD Policy: #213296**

**Phone: (866) 224-9402**

**Fax: (800) 447-2498**

**Monday - Friday  
8:00 am to 8:00 pm  
Eastern Time**

## **Reporting a Short Term Disability Claim by Telephone**

### **WHEN TO REPORT A CLAIM:**

- When your physician has determined you are unable to work due to illness, injury or pregnancy.
- Thirty days in advance of a planned medical absence, such as prescheduled surgery or an expected pregnancy leave.
- Please do not use this process to report a work related injury. When you are injured at work, contact your manager or supervisor immediately.

### **HOW TO REPORT A CLAIM:**

- Notify your manager or supervisor of your absence from work.
- Call the toll-free number (866) 224-9402 to initiate your claim. Refer to "Information Needed to Submit a Claim" to the right of this page; for a list of the information that is required to initiate a claim.
- See your physician and provide him/her with a signed and dated copy of the authorization form (attached). This authorizes the release of medical information needed to evaluate your claim.
- Fax or mail a copy of the signed and dated authorization to the UNUM Benefits Center.

### **OUR COMMITMENT TO YOU:**

**UNUM understands that a disabling illness or injury creates emotional, physical and financial challenges and we want to do whatever we can to help you. You have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.**

### **INFORMATION NEEDED TO SUBMIT A CLAIM**

**Please be prepared to provide the following information when you make your claim request. If someone else makes the call on your behalf, he/she may need the provide this information.**

- Employer Name - Calhoun County
- Policy number - 213296
- Physician's name, address, fax and phone number
- Your name and Social Security or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and phone number
- A brief description of your medical condition including cause of condition (illness or injury), date of injury or beginning of illness, and whether it's work-related
- The dates of your first visit, your most recent visit, and your next scheduled visit with your physician for this condition
- Your last day worked and your first day absent from work due to this condition
- The date you expect to return to work (if you know), or the actual date if you have already returned to work at the time you call
- Work restrictions or limitations advised by your physician, if any

***Prompt and complete information from you and your physician will help ensure a timely decision and payment if you are eligible.***



**SHORT TERM DISABILITY CLAIM FORM**

The Benefits Center  
P.O. Box 100158, Columbia, SC 29202-3158  
Pacific Time Zone Toll-free: 1-877-851-7637  
All Other Time Zones Toll-free: 1-800-858-6843  
Fax (All Time Zones) Toll-free: 1-800-447-2498  
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

**EMPLOYEE/INDIVIDUAL AUTHORIZATION – FOR EMPLOYEE TO COMPLETE**

Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

**Authorization**

**I authorize** health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Advocator Group and other Social Security advocacy vendors, The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

**To disclose** information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits;

**To the following persons:** Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

**For the purposes of evaluating and administering claims, including assistance with return to work.** Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

**Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.**

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Social Security Number

I signed on behalf of the Insured as \_\_\_\_\_ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.