You must submit the ORIGINAL forms via U.S. Mail

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

11301 Old Georgetown Road
Rockville, MD 20852-2800
(800) 638-6589 • Fax (301) 816-0191
www.SambaPlans.com

LONG TERM DISABILITY PLAN

Instructions to Submit a Claim for Benefits

- ***Member*** completes and signs the **LONG TERM DISABILITY PLAN REIMBURSEMENT AGREEMENT** and **AUTHORIZATION.**

- ***Member*** completes and signs the **MEMBER STATEMENT** and **EDUCATION AND EXPERIENCE**. Answer all questions as completely as possible. Use a separate sheet of paper, if necessary.

- Have your ***Employer*** complete and sign the **EMPLOYER STATEMENT**. We will also require a copy of your job description and leave statement.

- Have the ***Physician***, who is primarily responsible for your care, complete and return the **ATTENDING PHYSICIAN STATEMENT OF DISABILITY** directly to the SAMBA office. Any **fees required by your physician(s)** for copies of medical records or the completion of the **ATTENDING PHYSICIAN STATEMENT OF DISABILITY** are the **responsibility of the *Member***. Be sure your physician provides the full details of your claim and attaches copies of medical records including all of the dates attended, diagnoses, findings, observations, medications and/or treatment prescribed and, if applicable, referrals to any other physicians or specialists. If you are seeing more than one physician, have ***each physician complete a separate statement.*** Contact SAMBA for additional forms or make copies as needed. This form should be completed following the **elimination period**.

- Benefits begin the first day of **total disability** after the **elimination period**. The **elimination period** is a period of continuous **total disability** extending 60 consecutive days from the beginning of each period of **total disability**.

- Return all of the fully completed forms to:

SAMBA
Attn: Group Plans
11301 Old Georgetown Road
Rockville, MD 20852-2800

Answer <u>all</u> questions completely. This will help expedite your claim by avoiding unnecessary correspondence or delays.

If you have any questions, call 1-800-638-6589 or (301) 984-1440 in the Washington, DC area.

Reset

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Return to:
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Rockville, MD 20852-2800
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Fax: (301) 816-0191

LONG TERM DISABILITY PLAN
REIMBURSEMENT AGREEMENT

I am filing a claim for disability benefits under the SAMBA Long Term Disability ("LTD") Plan. I acknowledge receipt of the LTD Program Summary Plan Description dated January 1, 2004 ("SPD"). I fully understand and acknowledge that my monthly LTD benefits shall be reduced (but not below $200 per month) for the benefit offsets identified on pages 4-6 of the SPD, including, for example, Workers' Compensation, Social Security disability, and federal disability or other retirement benefits.

In accordance with the SPD, SAMBA has agreed to initially pay me my LTD benefit without deducting an estimate of any of the benefit offsets until I am eligible to receive them. In consideration of SAMBA's agreement, I agree to the following:

1. I promptly will file claims to secure each of the benefit offsets for which I may be eligible and I will furnish SAMBA with proof of such filing(s) and any resulting decision(s) immediately upon my receipt.
2. I will appeal any adverse decisions on benefit offset claims that an appeal is appropriate, for example, Workers' Compensation, Social Security disability and Federal disability or other retirement benefits.
3. If I receive any retroactive payments of benefit offsets, I agree not to use or disperse any part of such payments until I have contacted SAMBA to be sure no monies are due to SAMBA. I also will repay SAMBA the full amount of the benefit offsets that SAMBA determines are due under the terms of the SPD within 10 days after receiving SAMBA's determination. I also agree that after that 10 day period expires, interest will accrue on any SAMBA-determined overpayment at the rate of 14% per annum, compounded monthly, until the entire reimbursement, plus accrued interest, is received by SAMBA. I understand that I may appeal SAMBA's initial benefit offset determination under the Claim Appeal Procedures described on pages 10-11 of the SPD.
4. If I fail to comply with any of these obligations, I understand and agree that SAMBA may terminate my LTD benefits and that SAMBA may recoup its collection costs, including reasonable attorneys' fees, from me or from my beneficiaries in the event of my death.
5. With respect to any group life or accidental death and dismemberment coverage that SAMBA has issued to me, I hereby assign to SAMBA as creditor beneficiary, an amount of such coverage equal to the amount of any LTD benefit overpayment, including any accrued interest, which may be outstanding at the time of my death as determined by SAMBA.

Signature_____ Date_____ Plan Number_____

Print Name_____ Member ID Number_____

Street Address_____

City_____ State_____ Zip_____

<u>This section to be completed by Notary Public</u>

This instrument was acknowledged before me this _____ day of _____, 20_____

State of _____ County of _____

Signature _____

Print Name _____

My commission expires on _____

Notary Seal

SAMBA
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LONG TERM DISABILITY PLAN AUTHORIZATION

To all physicians, hospitals, medical service providers, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, Blue Cross Blue Shield, Social Security Administration, the Veterans Administration and Governmental Agencies, self insured and prepaid health plans), and specifically:

_____Hospital(s)

and Dr.(s)_____

You are authorized to permit SAMBA and any of its authorized representatives to view and obtain a copy of ALL RECORDS including employment, insurance claim and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric, drug, alcohol treatment and disease, including HIV and/or AIDS for:_____
Print Name of Member

I understand the information obtained will be used only by SAMBA and any of its authorized representatives to determine eligibility for insurance and benefits claimed under the Member's policy. I consent to re-disclosure to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to SAMBA. It will not affect any use or disclosure permitted by my authorization while it was in effect. This authorization will be valid, unless previously revoked, while the claim is pending but not to exceed a maximum of two years from the date below.

I understand that I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

Signature_____ Date_____

Print Name _____

Plan Number_____ Member ID_____

Street Address_____

City_____ State_____ Zip_____

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

EMPLOYER STATEMENT

(To be completed by the employer)

Return to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Employer: Print or type response. Attach copies of the job description and leave statement before mailing.

Employee's Name *(Last, First, MI)*	Social Security Number	Date of Birth
Employee's Home Address *(Street, City, State, Zip)*		

Employment

Agency	Occupation as of last date worked (attach job description)

Employee's Date of Hire	Supervisor's Name and Phone Number

Work schedule at time last worked (attach leave statement)

Office: # days per week _____ No. hrs per day _____ | Home/Other Residence: # days per week _____ No. hrs per day _____

Reason why employee stopped working

Last date employee was at work	Has employee returned to work? ❑ Yes ❑ No	Full-time Date	Part-time Date

Number of hours worked on last day	Is employee's job being held open? ❑ Yes ❑ No	Has employment been terminated? ❑ Yes ❑ No	Termination Date

Income

Employee's Earnings

Monthly $ Annual $

Other Benefits

Did disability result from job activity? ❑ Yes ❑ No	Has a Workers' Comp claim been filed? ❑ Yes ❑ No ❑ Pending ❑ Denied (enclose copy of denial)	Workers' Compensation weekly benefit $	Date Workers' Comp commenced
Has employee received income since date last worked? ❑ Yes ❑ No	Describe Source/type	Weekly Amount $	Date Benefits: Commenced_____ Ceased_____
Has employee received income since date last worked? ❑ Yes ❑ No	Describe Source/type	Weekly Amount $	Date Benefits: Commenced_____ Ceased_____
Has employee received income since date last worked? ❑ Yes ❑ No	Describe Source/type	Weekly Amount $	Date Benefits: Commenced_____ Ceased_____

Employer Name

Employer Name	
Employer Address *(Street, City, State, Zip)*	
This is to certify that the facts as indicated above are true to the best of my knowledge and belief. Signature of Employer Representative	Date Signed

Print Name and Title	Telephone Number	Fax Number

SAMBA
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MEMBER STATEMENT

(To be completed by the member)

Return to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Please print or type the information

Your Name *(Last, First, MI)*		Sex: ❑ Male ❑ Female	Date of Birth
Your Address *(Street, City, State, Zip)*			Phone Number ( )
Certificate Number	Social Security Number	Retirement Program ❑ CSRS ❑ FERS	Plan Number
Employer's Name			Employer Phone Number ( )
Employer's Address *(Street, City, State, Zip)*			
Job Title and Specific Duties			

Hours Worked Per Week	Length of Time with Employer	Length of Time in Latest Position	Gross Monthly Earnings
Nature of Illness or Injury		Initial date of illness or injury leading to disability.	Is the condition work related?
Date you Last Worked	If returned to work, advise date Part-time Full-time	If not, estimated date of return	Date first treated by physician for this disability

Describe fully your present disability and its cause, with a complete history to date. Attach a separate sheet if more space is needed.

List all physicians consulted and hospital confinements in the last five years. Attach a separate sheet of paper if needed. Indicate if your physician has been given the ATTENDING PHYSICIANS STATEMENT OF DISABILITY (APS) to complete for you.

Name of Physician/Hospital/Clinic	Address	APS Requested	Date of Treatment
_____	_____	❑ Yes ❑ No	_____
_____	_____	❑ Yes ❑ No	_____
_____	_____	❑ Yes ❑ No	_____

Describe other income you are receiving and/or have applied for:

Yes	No	Description	Amount	Date Began	Date Terminated
❑	❑	No Fault Auto Insurance	$_____	_____	_____
❑	❑	Veterans Administration	$_____	_____	_____
❑	❑	Social Security (disability or retirement)	$_____	_____	_____
❑	❑	State Disability	$_____	_____	_____
❑	❑	Retirement (normal, early, or disability)	$_____	_____	_____
❑	❑	Workers' Compensation	$_____	_____	_____
❑	❑	Group Disability Benefits	$_____	_____	_____
❑	❑	Leave Share	$_____	_____	_____
❑	❑	Other (describe)_____	$_____	_____	_____

_____

ACKNOWLEDGEMENT

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice at the bottom of this page.

_____ _____

Signature (if other than member, also print name and give relationship) Date

WARNING: It is a crime to provide false or misleading information to a plan for the purpose of defrauding the plan or any other person. Penalties include imprisonment and/or fines. In addition, a plan may deny benefits if false information materially related to a claim was provided by the applicant.

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MEMBER STATEMENT
EDUCATION AND EXPERIENCE

(To be completed by the member)

Return to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Please print or type the information

Education

	Name of School and Location	Dates Attended From Mo/Yr	To Mo/Yr	Major Course of Study	Degree
High School					
Junior College					
University					
Graduate					
Vocation or Trade					

Employment: List most recent employer first

Name of Employer	
Employer Address *(Street, City, State, Zip)*	
Date From	Starting position
Date To	Position at time of leaving
Briefly describe your responsibilities. Attach a separate sheet of paper if needed.	

Name of Employer	
Employer Address *(Street, City, State, Zip)*	
Date From	Starting position
Date To	Position at time of leaving
Briefly describe your responsibilities. Attach a separate sheet of paper if needed.	

Name of Employer	
Employer Address *(Street, City, State, Zip)*	
Date From	Starting position
Date To	Position at time of leaving
Briefly describe your responsibilities. Attach a separate sheet of paper if needed.	

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

ATTENDING PHYSICIAN STATEMENT OF DISABILITY

To be completed by the physician

(The patient is responsible for the completion of this form without expense to SAMBA.)

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Please print or type – Use a separate sheet of paper to answer questions where space does not permit.

Patient's Name *(Last, First, MI)*	Social Security Number	Date of Birth

Patient's Street Address	Telephone Number

City	State	Zip

I hereby authorize release of information on this form by the physician named on the reverse side of this form for the purpose of claim processing.

Signature _____ Date _____

To be completed by the attending physician

1. HISTORY

(a) When did symptoms first appear or accident happen? Month _____ Day _____ Year _____

(b) Date of first visit: Month _____ Day _____ Year _____

(c) Date you first advised patient to cease work: Month _____ Day _____ Year _____

(d) Has patient ever had same or similar condition? If yes, please state when and describe: ❑ Yes ❑ No

(e) Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown

2. MEDICAL CONDITION

(a) Diagnosis:

(b) Complications:

(c) Symptoms:

(d) OBJECTIVE FINDINGS (Please attach reports including X-rays, EKGs, lab data, and any clinical findings):

3. NATURE OF TREATMENT

(a) Date of last visit: Month _____ Day _____ Year _____

(b) What are the treatment plans?

(c) Surgery:

(d) Medications:

(e) Has this person been referred to another physician? ❑ Yes ❑ No
Name and address of this physician:

(f) Is further treatment required? If yes, please describe. ❑ Yes ❑ No

4. PHYSICAL LIMITATIONS

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

(a) Standing

(b) Walking

(c) Sitting

(d) Lifting

(e) Stooping

(f) Driving

(g) Other (describe)

5. Does this person have mental or nervous limitations? ❑ Yes ❑ No

If yes, please describe:

6. PROGNOSIS (Recovery and return to work date)

REMARKS:

Physician Name (Please Print)	Specialty	Telephone Number
Street Address		Fax Number
City	State	Zip

Signature _____ Date _____

REQUIRED ATTACHMENTS

After you have fully completed this form, please attach:

- **OFFICE NOTES for at least the past two years but longer if available**
- **TEST RESULTS**
- **HOSPITAL ADMISSION/DISCHARGE SUMMARIES**
- **CONSULTING PHYSICIAN REPORT**

Including the above information with the claim submission will allow us to make a more timely claim determination for your patient.

MAIL COMPLETED FORM AND OFFICE RECORDS TO:

SAMBA
11301 Old Georgetown Road
Rockville, MD 20852-2800