Read all forms | Complete all sections | Mail or Fax ALL completed forms

Questions? 866.257.0707 | ada.protective.com | ADAClaims@protective.com

Submit to: P.O. Box 2465 | Birmingham, AL 35201-2465 | **Fax:** 303.262.5462

INITIAL CLAIM PACKET: OFFICE OVERHEAD EXPENSE PLAN

Submission Instructions

Your initial documents consist of 3 forms:

- HIPAA Compliant Authorization for Release of Medical Information
- Member Statement
- Attending Physician's Statement

Instructions to Member:

- Answer all questions in full; date, sign and return the Member Statement and authorization form.
- Provide the Attending Physician's Statement to your treating physician to complete.
- Advise Attending Physician to attach copies of laboratory reports, x-rays, diagnostic test reports and clinical notes covering the 12-month period preceding disability through the present.
- Provide a complete copy of your most recently filed Federal Income Tax Return to include all Schedule(s) and W-2(s). Please include both Individual and Business Return(s).
- Provide copies of your individual monthly production reports for the 24-month period just prior to the date you became disabled. Please ensure these reports include description of service with applicable Current Dental Terminology (CDT) Codes and charges for the services provided.

Protective Life Insurance Company

INITIAL MEMBER STATEMENT | PLAN 1106 | Office Overhead Expense Plan

Read all forms | Complete all sections | Mail or Fax ALL completed forms

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1. Member Information

ADA Number

Home Phone

Mobile Phone

Full Legal Name

Email Address

Street Address

Date of Birth / /

City

State

ZIP

Height ft, in

Weight

Right or Left Hand Dominant

2. Dental Specialty or Occupation Prior to Disability:

☐ General Dentistry ☐ Orthodontist ☐ Periodontist ☐ Dental Surgeon ☐ Other: _____

3. Business Structure:

☐ Sole Proprietor ☐ S Corp ☐ Partnership ☐ Regular Corporation ☐ Other: _____

What percent are you legally liable for the business expenses?: _____

Employment Address

Office Phone

Fax Phone

City

State

ZIP

4. What is the nature of your present disability and medical condition?

Describe when you first noticed the symptoms?

5. Is present condition due to an accident? ☐ Yes ☐ No **Date of Accident:** / /

Describe how and where accident occurred. If motor vehicle accident, attach a copy of the police/accident report.

6. Date you became disabled: / / **Date Last Worked:** / /

Describe your work activities prior to disability.

Hours worked per week prior to disability:

7. Were your duties or work schedule impacted prior to your last date worked as a result of your disabling condition? ☐ Yes ☐ No

If "Yes", please indicate: Date of Impact: / / Reduced hours worked per week: _____

and describe the changes.

8. Have you returned to work in any capacity? ☐ Yes ☐ No

If "Yes", please provide: Date of Return to work: / / Current hours per week: _____

Current schedule and work activities:

9. Name and phone number of Primary Treating Physician: _____

Primary Treating Physician Name Phone Number

10. When did you first receive medical treatment? _____

11. Have you ever been treated for the same or related condition(s)? ☐ Yes ☐ No

12. Have you been hospitalized for the same or simliar condition in the past 12 months? ☐ Yes ☐ No

If "Yes", please provide hospital information: _____

Hospital Name Phone Number

Hospital Address Date of Admission / / Date of Discharge / /

13. List the names and addresses of all physicians or hospitals where you have been treated for the same or related condition(s):

Hospital Name Address Phone Number

Condition Date of First Visit / / Date of Last Visit / /

Hospital Name Address Phone Number

Condition Date of First Visit / / Date of Last Visit / /

Hospital Name Address Phone Number

Condition Date of First Visit / / Date of Last Visit / /

Hospital Name Address Phone Number

Condition Date of First Visit / / Date of Last Visit / /

14. Do you have plans to close or sell your practice? ☐ Yes ☐ No

Please include sales agreement, employment agreement, closing statement, and letters of intent.

Date of Sale / /

Date of Closure / /

15. Do you have any other disability or office overhead expense coverage? ☐ Yes ☐ No

If "Yes", please provide hospital information:

Company Name	Phone Number	Contact Person	Policy Number	Coverage Type	Coverage Amount

16. Have you hired, or do you have plans to hire, a replacement dentist? ☐ Yes ☐ No

You may be eligible for the **Salary Replacement Monthly Benefit** if you hire a replacement dentist to perform your duties while you are totally disabled. This benefit will be the lesser of (1) 50% of your full benefit and (2) the actual cost of compensation paid. This benefit is available for a maximum of 6 months. If you have hired a replacement dentist, we require a copy of the signed employment agreement, as well as copies of the tendered checks made payable to the replacement dentist.

OVERHEAD EXPENSES

We require submission of documentation, such as **profit and loss statements** or **revenue and expense statements** and **payroll registers** to verify covered monthly expenses for each month you claim a benefit. In addition, we require a copy of your prior year's **Federal Income Tax Return** be remitted.

If claiming residual disability, you will need to provide documentation of your **prior and current individual monthly production** as well.

Please see your certificate to determine Covered and Non-Covered Overhead Expenses.

Fraudulent Claim Warnings

New York: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

/ /

Print Name of Claimant | Signature of Claimant | Date of Signature

Social Security or Tax ID Number | Phone Number(s)

Select

Street Address | City | State | Zip

Protective Life Insurance Company

ATTENDING PHYSICIAN'S STATEMENT

Office Overhead Expense Plan

Read all forms | Complete all sections | Mail or Fax ALL completed forms

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1. Patient Information

Patient's Name _____ Date of Birth ___/___/___

ATTENDING PHYSICIAN INSTRUCTIONS:

- Complete Attending Physician's Statement
- Form must be dated and signed in physician's own handwriting
- **Attach copies of laboratory reports, x-rays, diagnostic test reports and clinical notes covering the 12-month period preceding disability through the present**
- Mail completed form and records to Protective Life Insurance Company (PLICO)

HISTORY:

Date symptom(s) first appeared or accident happened: ___/___/___

Date patient first consulted you for this condition: ___/___/___

Do you recommend patient work restrictions? ☐ Yes ☐ No If "Yes", date you recommend work restrictions: ___/___/___

From what date did you recommend patient cease work due to his / her condition?

___/___/___ Date of first visit ___/___/___ Date of last visit ___/___/___ Date of next office visit

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

___/___/___ Date of Discharge (if applicable)

DIAGNOSIS (including complications and ICD 10 codes):

Primary: _____ ICD 10 code: _____

Secondary: _____ ICD 10 code: _____

Please provide specific clinical findings to support diagnosis:

Please provide objective medical testing results to support diagnosis:

TREATMENT

Recommended treatment program including medications:

Projected treatment duration: ____/____/____ Duration start date ____/____/____ Duration end date

Is patient following recommended treatment: ☐ Yes ☐ No If "No", please explain:

Date and description of surgery (if applicable)**:** ____/____/____ Surgery date

Description of surgery (if applicable):

Name and Telephone Number of Surgeon(s):

Surgeon Name _____ Phone Number _____

Surgeon Name _____ Phone Number _____

Surgeon Name _____ Phone Number _____

Any prior hospitalizations for the same or related condition within the last 12 months? ☐ Yes ☐ No

Description of hospitalization (if applicable):

If there are current function considerations/limitations, please list specific work restrictions:

Please provide your Physical Impairment recommendations: (*as defined in U.S. Dept. of Labor Dictionary of Occupational Titles)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%)
- ☐ Class 2 - Medium / manual activity* (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity, capable of light work* (35-55%)
- ☐ Class 4 - Moderate limitations of functional capacity; capable of administrative (sedentary*) activity (60-70%)
- ☐ Class 5 - Severe limitations of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

What diagnostic and clinical findings support the Impairments noted above?: _____

PROGNOSIS

Based on the recommended treatment plan, what changes do you expect in the near future?:

Based on the nature of this condition, when is the expected recovery date for the patient to return to work?: ____/____/____

What date do you expect to release patient to return to work in a part-time or full-time capacity?

____/____/____ Part-Time

____/____/____ Full-Time

When is Maximum recovery expected?: ____/____/____

PSYCHOLOGICAL (if applicable)

DSM-IV Multi-Axial Diagnosis

Axis I

Axis II

Axis III

Axis IV

Axis V: Current GAF

Highest GAF Past Year

Baseline

Subjective Symptoms:

How have the subjective symptoms been verified?

Objective Findings (please attach copies of any testing or clinical findings):

In your opinion, do the objective findings support the level of subjective limitations reported by your patient: ☐ Yes ☐ No

Please explain:

Complete the following Impairment Ratings: (psychological)

Degree of Impairment (0-None; 1-Slight; 2-Moderate: 3-Significant; 4-Severe)

Interpersonal Relations		Daily Job Activities	
Daily Social Activities		Ability to Think and Reason	
Sustain Work Performance		Concentration	
Present Memory		Disturbance	
Judgment		Suicidal Ideation / Intent	

Please describe Affect (e.g. appropriate, inappropriate; labile, stable, flat, etc.):

Are the patient's problems related to drug or alcohol abuse? ☐ Yes ☐ No

Specify any other factors which may have precipitated this condition and may affect prognosis for recovery:

Fraudulent Claim Warnings

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Attending Physician's Name (Please Print) | Physician's Signature* | Date of Signature / /

Degree / Board Certification | Phone Number | Fax Number

Street Address | City or Town | State or Province Select | Zip

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life / Disability Claim(s).

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me that may affect my claim(s). Protective Life and its reinsurers for the investigation of my claim(s) for insurance benefits may:

a. obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I authorize the following persons and organizations to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
c. insurers; reinsurers; affiliated companies, agents, legal and investigative services;
d. medical and vocational vendors;
e. my current and previous employers;
f. MIB, LLC. **(MIB)**; and commercial consumer reporting agencies **(CRA)**.

All of these persons and organizations other than **MIB** may release the information described above to a **CRA (such as Equifax Medical Services)** acting for Protective Life. **MIB** may not release the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to a **CRA**.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I authorize Protective Life to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting or claims for Protective Life, MIB and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, its affiliated companies, the insured's insurance agent(s) servicing the insured's policy/policies and person, organizations providing services, including legal services , investigation services and claims administration.

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GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or, in the event of a claim for benefits, for the duration of such claim.

b. Revocation of this Authorization: I understand that I have the right to revoke this authorization by writing to Claims Administration, P. O. Box 12486, Birmingham, AL 35202. I also understand revocation of this authorization will not affect any action taken in reliance on this authorization before Protective receives written notice of the revocation nor will the revocation be effective to the extent other law provides Protective with the right to contest a claim under the policy or the policy itself.

c. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, underwriting, or claims for the evaluation of life, disability, health, long-term care, or other insurance products.

d. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life, disability or other insurance product claim file.

e. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.

f. ***I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.***

AUTHORIZATIONS

I have had full opportunity to read and consider the contents of this authorization. I understand that I may refuse to sign this authorization and that Protective does not condition payment of a claim for benefits on whether or not I sign this authorization. I further understand that pursuant to the policy, Protective is eligible to require written proof of loss to process a claim under the policy. I also understand that by signing this form I am granting to Protective the authority to obtain, use and disclose information as described for the purpose stated in this form. I further understand that if the person(s) or organization I authorize to obtain or use the information through this authorization are not subject to federal information privacy laws, they may disclose the information, and it may no longer be protected by the federal health information privacy laws.

/ /
Date of Authorization

Insured Member's Name (Please Print) | Insured Member's Signature

/ /
Date of Birth | Social Security Number

Parent or Legal Guardian's Name (Please Print) | Parent or Legal Guardian's Signature (If minor)

Personal Representative / Next of Kin / Power of Attorney Name (Please Print) | Personal Representative / Next of Kin / Power of Attorney's Signature

Fraudulent Claim Warnings

Any person with intent to defraud who files an application or a claim containing false or misleading information is guilty of insurance fraud. Anyone who knows that someone is committing fraud against an insurer is guilty as well.

Some states require that we provide specific fraud claim warning language. Before signing the claim form, please read the warning for the state where you live and the state where the insurance policy was issued.

Arkansas, Louisiana, Rhode Island, West Virginia: 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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents a false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to civil and criminal penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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, and 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false incomplete, or misleading information is guilty of a felony in the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company of 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.

Maine: 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 a denial of insurance benefits.

Maryland: “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.” MD code Ann. Ins. HB 301' 27-805.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. 638:20.

Fraudulent Claim Warnings (Continued)

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties.

Ohio: 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.

Oklahoma: 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 false, incomplete, or misleading information is guilty of a felony.

Pennsylvania: 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 materially false information or conceals for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with intention of defrauding presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee: 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.

Texas: 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.

Virginia, Washington: It is a crime to knowingly present 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.

All Other States: 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. (NAIC Model).