MESSA
Good health. Good business. Great schools.

1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
517.332.2581 or 800.247.6951
Fax: 517.336.4042

Member Report For

Short and Long Term Disability Income Benefits

THESE BENEFITS ARE PAID UNDER A POLICY UNDERWRITTEN BY LIFE INSURANCE COMPANY OF NORTH AMERICA.

In order to process your claim rapidly, please answer ***all*** questions.

Do not complete this form prior to your last day worked.

Member Information *(please print)*

Member Name	Date of Birth (mm/dd/yy)	Social Security Number	Phone
			( )
Address	**City**	**State**	**Zip Code**

Illness / Injury Information

- Nature of illness or injury: _____ What was the last day you were at work? (m m / d d / y y)
- Are symptoms due to illness or caused by accidental injury? ☐ Illness ☐ Injury ☐ Auto injury

If **illness**, give date symptoms first appeared: (m m / d d / y y)

If **injury**, give date of accident: (m m / d d / y y)

Date you received medical advice or treatment for this condition: (m m / d d / y y)

- How and where did the injury occur? _____

• If auto related, please provide the following:	Name of Auto Carrier	Phone	Policy Number
		( )	

- Is this claim the result of a work-related illness or injury? ☐ Yes ☐ No

If yes, what are your intentions?

☐ I have applied for workers' compensation.
☐ I may apply for workers' compensation.
☐ I do not intend to apply for workers' compensation.

- Is this claim the result of a 3rd party incident? ☐ Yes ☐ No

If yes, what are your intentions toward recovery?

☐ I have obtained legal counsel. If yes, name and phone number: _____
☐ I may obtain legal counsel.
☐ I do not intend to obtain legal counsel.

MESSA has a right of recovery provision which states you are obligated to inform MESSA prior to settlement of any workers' compensation or 3rd party claim.

- Have you had any previous periods of disabilities within the past 12 months? ☐ Yes ☐ No If yes, date: (m m / d d / y y)

Physicians and/or therapists who have treated you for this illness/injury:

Name	Provider's Specialty	Address	Phone
			( )
Name	Provider's Specialty	Address	Phone
			( )
Name	Provider's Specialty	Address	Phone
			( )

over please ➡

Disability and home / hospital confinement

- Have you been confined to a hospital? ☐ Yes ☐ No If **yes,** please give dates: From (mm/dd/yy) Through (mm/dd/yy)
- Have you been confined to your home? ☐ Yes ☐ No If **yes,** please give dates: From (mm/dd/yy) Through (mm/dd/yy)
- If you have recovered or returned to work, give date:
- If still totally disabled, when do you expect to return to work? (mm/dd/yy)
- Have you engaged in any work, part-time or otherwise, since your disability began? ☐ Yes ☐ No
  If **yes**, please explain and give dates: _____
- What are your job duties? _____

School / Work Information

- How many total years have you been employed by a Michigan Public School? _____ years

Are you retired? ☐ Yes ☐ No | If **yes**, please give date of retirement: (mm/dd/yy)

- Are you receiving any income benefits as a result of your disability? ☐ Yes ☐ No
  If **yes**, please check the following that apply:

☐ Pension Plan
☐ Michigan Public School Employees Retirement (MPSER)
☐ Primary (self only) Social Security
☐ Family Social Security
☐ Workers' Compensation or Occupational Disease
☐ Federal, State, Provincial or other Governmental Disability or Benefit Law
☐ Salary Continuance Plan or sick pay
☐ Any other benefits, including vacation pay
☐ Non-coordinated auto wage loss benefits
☐ Railroad Retirement
☐ Any other income from your employer, self-employment, labor-management
☐ Trustee or union employee benefit plan

Type of Benefit	Amount (Weekly or Monthly)	Date Benefits Began or will Begin	Date of Termination of Benefits
	$	(mm/dd/yy)	(mm/dd/yy)
	$		

If you receive income from any of the sources listed, please notify MESSA immediately. Failure to notify MESSA will result in an overpayment of your disability benefits. You will be responsible to repay any overpaid amount. **Your signature here acknowledges you have read this statement and you agree to reimburse MESSA any overpaid amount.**

SIGN & DATE HERE	Signature	Date
	X	

Family Information and Disclosure Authorization

Name of Spouse	Date of Birth (mm/dd/yy)
Name of Unmarried Child	Date of Birth
Name of Unmarried Child	Date of Birth
Name of Unmarried Child	Date of Birth
Name of Unmarried Child	Date of Birth

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Disclosure Authorization

For claims incurred before July 1, 2005 MESSA Disability benefits are underwritten by the Connecticut General Life Insurance Company. All other MESSA Disability Benefits are underwritten by the Life Insurance Company of North America.

Claimant's Name (Please Print Here)

X _____

Claimant's Name (Please Print)

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; any of your social security disability advocates or representatives; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer, union, and/or group association sponsors any other plans, whether or not underwritten or administered by a Cigna company or MESSA, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Company, the Plan, insurers, or other providers of services or benefits related to the Plan who rely on this authorization may not be able to evaluate or administer my request for Plan benefits, coverage or services and that my request for Plan benefits, coverage or services may be denied as a result. I may revoke this authorization at any time by sending written notice to the claim manager handling my claim.

Signature & Date of Claimant *or* Authorized Representative Here

X _____ _____

Signature of Claimant — Date

Relationship, if other than Claimant: _____ If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Claimant's Social Security Number: _____ Claimant's Phone Number: _____

Claimant's Date of Birth: _____

Company Name: **Michigan Education Special Services Association (MESSA)** **800.247.6951** **Fax: 517.336.4042**

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