Nationwide is on your side

Disability Insurance Specialists, LLC

Disability Insurance Specialists (DIS) provides disability claim services for Nationwide group disability policies.

To report a short-term disability claim, please call 1-800-654-3826

Nationwide Employee Benefits offers the convenience of reporting short-term disability claims utilizing a telephonic intake process. Below are step-by-step instructions to report a short-term disability claim through our telephonic intake process. If you prefer to use the paper claim form, please log on to the Nationwide employer portal (nebsupport.com) to download the form or contact Disability Insurance Specialists at 800-654-3826.

- For a scheduled absence, a short-term disability claim should be reported 15 days in advance of the absence
- For unexpected absences, a short-term disability claim should be reported as soon as possible, but no later than 15 days after the first day of absence

Telephonic Claim Intake Process

To report a short term disability claim:

1. Please have your Nationwide Employee Benefits group account number (located on your disability billing invoice or policy) along with the following information for the disabled employee prior to making the call:

   - Disabled employee's name and contact information
   - Social Security Number
   - Date of birth
   - Date of disability
   - Employer name
   - Supervisor or employer contact name, address and phone number
   - Name and contact information of treating physician(s)
   - Brief description of disabling condition

2. Call 1-800-654-3826 during our normal business hours from 8:30 am-5 pm EST, Monday through Friday. The employer representative or disabled employee can report the claim. Customer service will explain what can be expected while the disability claim is pending an initial decision. If you call outside of normal business hours, please leave a voicemail and your call will be returned the next business day.

3. Mail or fax a signed HIPAA Authorization form completed by the disabled employee (see reverse side of this sheet):

   Disability Insurance Specialists
   P.O. Box 29
   Bloomfield, CT 06002
   Fax: 860-769-6981

Our short-term disability direct reporting unit is staffed with professionals dedicated to providing an exceptional customer experience. As soon as we receive report of a disability, we will:

- Assign a claims examiner to evaluate the claim.
- Send any necessary claim forms directly to the employer, employee or physician.
- Contact the employee, employer, and physician for information as needed throughout the claim evaluation process.
- Review the claim once all required information is received, and communicate a claim decision

Prompt claim reporting benefits everyone. If you have any questions relating to a new or existing disability claim, please feel free to call us at 1-800-654-3826.

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HIPPA Authorization: To Be Completed by Employee

TO:

- Physicians and Other Health Care Professionals
- Consumer Reporting Agencies and Credit Report Bureaus
- Employers
  Group Policyholders, Contract Holders/Vendors, Claims Administrators or their successors
- Governmental Agencies (including and not limited to the Social Security Administration ("SSA"), Internal Revenue Service, Veterans' Administration, Railroad Retirement Board, Jones Act Administration, and State Retirement Systems)
- Hospitals, Clinics and Health Care Facilities
- Insurers, including worker's compensation
- insurers or administrators, and Pre-Paid Health Plans
- Pharmacies and Pharmacy Benefit Managers
- State Vocational Rehabilitation Agencies and other providers of rehabilitation services
- Medical Information Bureau (MIB) or other companies, which collect health and insurance information
- Attorney Representatives, or advocates for SSA benefits

You are authorized to provide information related to my health condition and job modifications/accommodations with my current or future employer to:

- Disability Insurance Specialists (DIS);
- The plan administrator or claim administrator of any benefit plan under which I may be a participant; or
- Claims investigators, attorneys, physician consultants and other service providers involved in the administration, evaluation, and management of the plan and/or claim.

This form allows the release of the following information, collectively referred to as "Information":

- Records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations and prescriptions;
- Employment-related information, including any claims for workers' compensation;
- Income and tax-related information;
- Information from credit reporting bureaus or other consumer reporting agencies; and
- Information regarding insurance coverage or pension benefits, including claims submitted and benefits paid.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering benefits for short term disability, long term disability, salary continuation, workers' compensation, which are excepted benefits under HIPAA, or any other benefit program offered by and through the employer (hereinafter collectively referred to as "Benefits Program"), developing a vocational rehabilitation plan, and other purposes in connection with the administration of the Benefits Program.

I further authorize re-disclosure of any Information obtained or developed in the course of managing and/or administering the Benefits Program to the plan administrator or claim administrator of any Benefits Program under which I may be a participant, employers, reinsurers, the SSA, claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the Benefits Program. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain in force for a period of 24 months or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address above. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of DIS to process my claim and may lead to the denying or terminating of my claim for benefits.

Claimant Signature: _____ Date: _____

Claimant's Full Name: _____ Date of Birth: _____
If the insured is unable to sign, an authorized representative may sign below for the insured.

Representative Signature: _____ Date: _____

Name and Description of Representative's Authority to Sign: _____