This-2.3 ( )TjETEMC /Artifact <</MCID 31 >>BDC 66.36 448.92 0.481

	Does the company have Individual Employer Paid Long-Term coverage to report?	Yes/No
1-05	Does the company have Group Voluntary Short-Term coverage to report?	Yes/No
1-06	Does the company have Group Voluntary Long-Term coverage to report?	Yes/No
1-07	Does the company have Group Employer-Paid Short-Term	

Each product will represent a unique mix of three characteristics related to method of paym2.9 (o4-096 (Td[

4–35	Number of claims closed without payment within 1-14 days (Short term)
4–36	Number of claims closed without payment within 15-30 days (Short term)
4–37	Number of claims closed without payment within 31-45 days (Short term)
4–38	Number of claims closed without payment over 45 days (Short term)
4–39	Median Processing Time: The median processing time for claims closed without payment reported in 4-35 through 4-38 (Short term)
4–40	Number of claims closed without payment within 1-30 days (Long term)
4–41	Number of claims closed without payment within 31-60 days (Long term)
4–42	Number of claims closed without payment within 61-90 days (Long term)
4–43	Number of claims closed without payment over 90 days (Long term)
4–44	Median Processing Time: The median processing time for claims closed without payment reported in 4-40 through 4-43 (Long term)

5–45	Claimant not covered under the policy as of date of disability onset
5–46	Claimant returned to work during elimination period
5–47	Pre-existing condition
5–48	Claimant not disabled under the policy definition of disabled
5–49	Lack of documentation
5–50	Disability arising from diagnosis excluded under the policy
5–51	Disability due to work-related injury or condition excluded under the policy
5–52	Disability caused by excluded condition or circumstance other than a work-related injury
5–53	Misrepresentation
5–54	All other denials

6–55	Claimant returned to work – own occupation/job
6–56	Claimant returned to work – any occupation/job
6–57	Lack of documentation
6–58	Non-participation in evaluation
6-59	Death of claimant
6–60	Failure to participate in rehabilitation
6–61	Misrepresentation
6–62	Claimant had offsetting compensation
6–63	

—The MCAS Administrator is the person responsible for preparing and filing the DI MCAS repc 1.322.2 (19(CA).)-2 (s)]TJ0 Tc 0 T0j0.554 0 Td( )TjC 1B/P <<2nation >>BTj/TT1 1 Tf-0.

—(1-16) Reporting entities should provide any additional information related to features or characteristics of their DI business in a given state that would assist department personnel in interpreting specific data or in analyzing this MCAS report.

—(2-22) Report the number of claims with an initial benefit determination resulting in payment that are closed or are no longer receiving payments during the reporting period.

—(2-23) Report the number of open or pending claims for which no decision to pay or deny has been made as of the end of the reporting period (December 31).

—(2-24) Report the number of claims for which payment

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—(6-57) Include claims in which payment has been terminated due to a failure to obtain documentation pertaining to medical records, earnings loss, or any other evidence of continued disability.

—(6-58) Payment termination due to the failure to an insured to comply with a reporting entity's requirements for an independent medical, occupational or other similar evaluation.

—(6-59)

—(6-60) Instances in which an insured refuses to comply with policy requirements pertaining to participation in rehabilitation, worksite accommodations, or other program designed to facilitate a return to employment.

—(6-61) See definition under schedule 5 (5-52); in the context of a claim denial.

—(6-62()Tj0.38 0 Td(6)Tj0.543 0 Td(-)Tj-0.002 Tc 0.002 Tw 0.359

—(9-84) The number of lawsuits in process that have not been resolved or closed at the beginning of the reporting period (January 1).

—(9-85) The number of new lawsuits filed against the reporting entity at any time during the data year.