

SHORT TERM DISABILITY CLAIM FORM

PART A - EMPLOYEE STATEMENT - Failure to Answer All Questions May Delay Payment

1. Employee's Name					Street Address					City					State					Zip Code				
2. Group Number					Social Security No.					Are You Still Employed?					If No, Date Last Worked									
					Yes _____ No _____																			
3. Date of Birth					Name of Your Employer										Occupation									
4. Is Claim for an Accident?					Date:					Where Did it Occur?					While Working?					How Did it Occur?				
Yes _____ No _____					Time:										Yes _____ No _____									
<p>5. I hereby make this Claim Statement and authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, having information available as to the diagnosis, advice, treatment, care and prognosis with respect to any physical or mental condition of myself or the above listed individual to provide all such information. I further UNDERSTAND the information so obtained will be used for claim purposes only. I KNOW that I have a right to receive a copy of this authorization and that a photocopy is as valid as the original. I further agree that this authorization will be valid for two years from the date shown below. I certify that the above information is true and correct. I further understand a person who submits an application or file a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime</p>																								
SIGN HERE:												DATE:												

PART B - DOCTOR - Complete and Return to Patient

Patient					Date of Birth					Is Disability Related to Work														
										Incurred Injury or Illness Yes _____ No _____														
Date First Seen					Date of					Date Patient Able					Date of Partial									
					Total Disability					to Return to Work					Disability From					Through				
Diagnosis																								
Dates of Care for					In Hospital					Home Confined														
the Disability					From					Through					From					Through				
Signature of Physician or Supplier																								
Signed												Date												
Provider's Social Security Number / Tax ID Number					Physician's Name, Address, Zip Code										Telephone No.									
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PART C - EMPLOYER/PLAN ADMINISTRATOR'S STATEMENT

1. Policy Name					Division Name																								
					If Applicable																								
2. Effective Date of Coverage					Date of Termination																								
3. Date Employee Last Worked					Reason for Leaving					Date Returned to Work					Occupation					Weekly Wage					Patient Entitled to Wk Comp for This Claim?				
4. I HEREBY RECOMMEND THIS CLAIM RECEIVE CONSIDERATION																													
AUTHORIZED SIGNATURE:												DATE:																	