



Administered by

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, IL 60173
Phone: 1-800-323-1683/847-519-1880
Fax: 1-847-519-1979

Supplemental Disability Claim

Statement Of Employee

Your name Telephone Number ()
Your occupation Date of birth Social Security No.

SUPPLEMENTAL DISABILITY CLAIM

UPDATED ATTENDING PHYSICIAN'S STATEMENT

CURRENT DATES OF TREATMENT

Date of last visit Mo. Day 20
Frequency Weekly Monthly Other (Specify)

PROGRESS

(a) Has patient Recovered? Improved? Unchanged? Retrogressed?
(b) Is patient Ambulatory House confined? Bed confined? Hospital confined?
(c) Has patient been hospital confined? Yes No If yes, give Name and Address of Hospital Confined from through

CARDIAC (If Applicable)

(a) Functional capacity Class 1 (No limitation) Class 2 (Slight limitation) Class 3 (marked limitation) Class 4 (Complete limitation)
(b) Blood Pressure (last visit) SYSTOLIC DIASTOLIC

PROGNOSIS

(a) Is patient now totally disabled?
(b) What duties of patient's job is he/she incapable of performing?
(c) Do you expect a fundamental or marked change in the future?
(d) If yes, when will/or did patient recover sufficiently to perform duties
Remarks

PATIENT'S JOB

Yes No
Yes No
Yes No
1 mo. 3-6 mo.
1-3 mo. Never

ANY OTHER WORK

Yes No
Yes No
Yes No
1 mo. 3-6 mo.
1-3 mo. Never

REHABILITATION

(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.) Yes No
(b) Can present job be modified to allow for handling with impairment? Yes No

PATIENT'S JOB

Full-time Part-time
Mo. Day Yr. Mo. Day Yr.

ANY OTHER WORK

Full-time Part-time
Mo. Day Yr. Mo. Day Yr.

(d) Would vocational counseling and/or retraining be recommended? Yes No

PRINT Physician's Name Degree Specialty Telephone
Street Address City State or Province Zip Code
Date Signature Tax Identification Number

Authorization For Release Of Information

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Group Administrators, Ltd., or lists representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

These statements are true and complete to the best of my knowledge

Date Signature of Employee

Address of Employee Street City State Zip Code

Is this a new address? Yes No