



STATEMENT OF EMPLOYER

Employee's Name _____		I.D. No. _____	Unit or Div. No. _____	
Benefit Plan _____	Date of Employment _____	Eff. Date of Plan _____	Eff. Date of Last Change _____	
%	\$			
Percentage of premium paid by Employer _____	Salary continuance or sick pay _____	Paid from _____	Thru _____	
Was coverage in force when disability began?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Employee last worked _____		
Is Employee's coverage still in force?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, give date of termination _____		
Has Employee returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give date returned _____		
Type and Amount of Benefit Claimed:	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Life Coverage During Disability	
	\$	\$	\$	
Employee's Salary: Monthly: \$ _____	Weekly: \$ _____	Eff. Date of Salary: _____		
Employer _____			Plan No. _____	
Date _____	By (Signature) _____	Title _____	Telephone # _____	

INSTRUCTIONS TO EMPLOYEE

- | | |
|--|---|
| (1) This form is to be filed as soon as it appears that you will qualify for disability benefits.. | (3) Have your physician complete the Attending Physician's Statement on the reverse side. |
| (2) Complete the Statement Of Employee and the Authorization For Release Of Information below. | (4) Return Form to your Employer. |

STATEMENT OF EMPLOYEE

Your Name _____		Telephone Number _____	
Your occupation _____		Date of birth _____	Social Security No. _____
When did you become wholly unable to work? _____	Date _____	Hour _____ A.M.	_____ P.M.
Have you been continuously disabled since you became unable to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, approximately when do you feel you will be able to resume work? _____			
If no, when did you again become able to work? Date _____ Hour _____ A.M. _____ P.M.			
Is disability due to <input type="checkbox"/> accident or <input type="checkbox"/> sickness. (If accident, describe, including date and place. If sickness, when did symptoms first appear?) _____			
Have you been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when? From _____ To _____			
Name of hospital _____		Address _____	
Did disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, amount of Workers' Compensation benefit: \$ _____			
Do you have disability insurance with other companies? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, give names of companies and policy numbers: _____			
Name and address of your doctors during the past year ▼ _____		Sickness or Injury ▼ _____	Date Consulted ▼ _____
These statements are true and complete to the best of my knowledge _____			
			(Date)

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 its 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.

Date _____	Signature of Employee _____	Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address of Employee _____		
Street	City	State Zip Code

DISABILITY CLAIM

ATTENDING PHYSICIAN'S STATEMENT

1. HISTORY

- (a) When did symptoms first appear or accident happen?
(b) Date patient ceased work because of disability?
(c) Has patient ever had same or similar condition?
(d) Is condition due to injury or sickness arising out of patient's employment?
(e) Names and addresses of other treating physicians

2. DIAGNOSIS

- (a) Diagnosis (including any complications)
(b) Subjective symptoms
(c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

- (a) Date of first visit
(b) Date of last visit
(c) Frequency

4. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)

5. 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

6. CARDIAC (If Applicable)

- (a) Functional capacity Class 1 Class 2 Class 3 Class 4
(b) Blood Pressure (last visit) SYSTOLIC DIASTOLIC

7. PROGNOSIS

- (a) Is patient now totally disabled? PATIENT'S JOB ANY OTHER WORK
(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

8. REHABILITATION

- (a) Is patient a suitable candidate for further rehabilitation services?
(b) Can present job be modified to allow for handling with impairment?
(c) When could trial employment commence?
(d) Would vocational counseling and/or retraining be recommended?

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