



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? **Yes** **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 **accident** or **sickness**. (If accident, describe, including date and place. If sickness, when did symptoms first appear?) _____

Have you been hospital confined? **Yes** **No**. If yes, when? From _____ To _____

Name of hospital _____ Address _____

Did disability result from employment? **Yes** **No**. If yes, amount of Workers' Compensation benefit: **\$** _____

Do you have disability insurance with other companies? **Yes** **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 _____
(Signature of Employee) _____ (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? **Yes** **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?..... Mo. _____ Day _____ Year _____
- (b) Date patient ceased work because of disability?..... Mo. _____ Day _____ Year _____
- (c) Has patient ever had same or similar condition?..... **Yes** **No** *If "Yes" state when and describe*

- (d) Is condition due to injury or sickness arising out of patient's employment?..... **Yes** **No** **Unknown**
- (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 Mo. _____ Day _____ Year _____
- (b) Date of last visit..... Mo. _____ Day _____ Year _____
- (c) Frequency **Weekly** **Monthly** **Other** (Specify) _____

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 _____

- Confined from _____ through _____

6. CARDIAC (If Applicable)

- (a) Functional capacity (American Heart Association) **Class 1** (No limitation) **Class 2** (Slight limitation)
- Class 3** (Marked limitation) **Class 4** (Complete limitation)
- (b) Blood Pressure (last visit) /

SYSTOLIC
DIASTOLIC

7. PROGNOSIS

- (a) Is patient now totally disabled? **PATIENT'S JOB** **Yes** **No** **ANY OTHER WORK** **Yes** **No**
- (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? **Yes** **No** **Yes** **No**
- (d) If yes, when will/or did patient recover sufficiently to perform duties?
 _____ _____
 1 mo. **3-6 mo.** **1 mo.** **3-6 mo.**
 1-3 mo. **Never** **1-3 mo.** **Never**

Remarks _____

8. 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**
- (c) When could trial employment commence? **PATIENT'S JOB** **Full-time** **Part-time** **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 _____