Supplemental Disability Claim

Administered by

Group Administrators, Ltd.
20 North Martingale Rd.
Suite 290
Schaumburg, IL 60173
Phone: 1-800-323-1683/847-519-1880

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 (American Heart Ass'n.) Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (Complete limitation) ☐

(b) Blood Pressure (last visit) _____ / _____ SYSTOLIC DIASTOLIC

PROGNOSIS

		PATIENT'S JOB	ANY OTHER WORK
(a)	Is patient now totally disabled?	☐ Yes ☐ No	☐ 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. ☐1-3 mo. ☐ Never	☐ ___/___/___ ☐1 mo. ☐ 3-6 mo. ☐1-3 mo. ☐ Never

Remarks _____

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	ANY OTHER WORK
(c)	When could trial employment commence?	___/___/___ Mo. Day Yr. Full-time ☐ Part-time ☐	___/___/___ Mo. Day Yr. Full-time ☐ Part-time ☐

(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 ☐