Administered by:
Group Administrators, Ltd.
20 North Martingale Rd, Suite 290 • Schaumburg, IL 60173 • (847) 519-1880 • www.groupadministrators.com • fax (855) 978-2331

Disability Claim

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? ☐ **Yes** ☐ **No** Date Employee last worked

Is Employee's coverage still in force? ☐ **Yes** ☐ **No** If no, give date of termination

Has Employee returned to work? ☐ **Yes** ☐ **No** If yes, give date returned

Type and Amount of Benefit Claimed: ☐ **Long Term Disability** $ ☐ **Short Term Disability** $ ☐ **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..

(2) Complete the **Statement Of Employee** and the **Authorization For Release Of Information** below.

(3) Have your physician complete the Attending Physician's Statement on the reverse side.

(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

	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 mo.**	☐ **3-6 mo.**
Remarks _____	☐ **1-3 mo.**	☐ **Never**	☐ **1-3 mo.**	☐ **Never**

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**

	PATIENT'S JOB	ANY OTHER WORK
(c) When could trial employment commence?	_____ Mo. Day Yr.	_____ Mo. Day Yr.
	☐ **Full-time** ☐ **Part-time**	☐ **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

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