HOUSE STAFF BENEFITS PLAN

520 EIGHTH AVENUE, SUITE 1200, NEW YORK, NY 10018-4181

Phone: (212) 356-8180 Fax: (212) 356-8181 benefits@cirseiu.org http://www.cirseiu.org/benefits

SHORT TERM DISABILITY BENEFITS CLAIM FORM

Eligibility: Supplemental Short-Term Disability Benefits will begin on the eighth day of a non-occupational disability and continue through the twelfth week. This benefit is available for the participant only. The participant's spouse and other dependents are not eligible for this benefit.

Maximum: 70% of your basic weekly salary up to a maximum of $875 per week.

Claim Submission Rules:

- If you are eligible for state-mandated disability benefits, obtain a claim form for those benefits from your HR department and submit it according to instructions.
- You and your physician must complete this form.
- Once you begin to receive any statutory benefits, submit the check stub for these benefits with your completed claim form.

Please complete the following:

Participant's Name: ______________________________ ______ ______________
(Last Name) (First Name) (Date of Birth)

Social Security No.: ________________ Hospital where employed: ______________________

Home Address: ____

____
(City) (State) (Zip code)

Contact phone number: ______________ Type (home, mobile, etc.) __________ E-mail address: ________________

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY:

The participant is responsible for the completion of this form. The Plan must have comprehensive medical information in order to evaluate the insured's eligibility for disability benefits.

1. History:

(A) When did the symptoms first appear or accident happen? Month____________ Day____ 20____

(B) Date the patient ceased work because of disability. Month____________ Day____ 20____

(C) Has the patient ever had the same or similar condition? Yes ( ) No ( ) If "yes" state when and describe: ____________

____

____

2. Present Condition:

(A) Subjective symptoms ____

____

(B) Objective findings. Include results of current X-rays, EKG or any other special tests. ____________________

____

____

(C) Is the patient ambulatory? ____ Bed confined? ____ Hospital confined? ____ House Confined ____

3. Diagnosis: ____

____

4. Treatment:

(A) Date of first visit: Month____________ Day____ 20____

(B) Date of last visit: Month____________ Day____ 20____

(C) Frequency of visits: Weekly Monthly Other

(D) When did you last examine the patient? Month______________ Day____ 20____

5. Progress: Recovered?____ Improved?____ Unimproved?____ Retrogressed?____

6. Extent of Disability:

(A) Is the patient not totally disabled?

For any occupation: Yes____ No____ For his/her regular occupation: Yes____ No____

(B) If "no," when was the patient able to go to work?

For any occupation: Yes____ No____ For his/her regular occupation: Yes____ No____

(C) If "yes," when do you think the patient will be able to resume any type of work?

Approximate date: Month______________ Day____ 20____ Indefinite____ Never____

(D) If "yes," is this patient a suitable candidate for rehabilitation? Yes____ No____

7. Pertinent Laboratory Findings: Urinalysis required. Blood count, blood chemistry, etc. If there is limitation, check below.

Limitation: Standing____ Climbing____ Bending____ Use of hands ____ Walking ____ Stooping ____

Lifting ____Psychological ____

Prescribe the function impairment and include any comment regarding the patient, his or her attitude, behavior, etc.

8. Mental Condition: Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes____ No____

9. Cardiac Function Capacity: (American Heart Association)
Class 1 (No limitation)____ Class 2 (Slight Limitation)____ Class 3 (Marked Limitation)____

Class 4 (Complete limitation)____

10. Significant Medical History: (Past and present) Attach pertinent consultation, laboratory or X-ray report copies.

11. Physical Examination: (General appearance)

Height____ Weight____ Pulse rate____ Blood pressure____

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Eye	_____	_____	Heart	_____	_____	Nervous Sys.	_____	_____
Ear	_____	_____	Abdomen	_____	_____	Skin	_____	_____
Teeth	_____	_____	Ano-rectal	_____	_____	Lymph nodes	_____	_____
Neck	_____	_____	Varicosities	_____	_____	Genio-urinary	_____	_____
Lungs	_____	_____	Musculo-skelet	_____	_____	other	_____	_____

Please describe abnormalities. You may attach copies of recent physical examination. ______________________________

____

12. Impairment: Indicate how impairment will affect the patient's ability to work.

13. Treatment: Will treatment substantially improve function and employability? Yes____ No____
If "yes," please describe ____

____

Note: A copy of a recent narrative report submitted to another insurance or government agency will suffice in lieu of answering question 1.

Attending Physician: ___________________________ ______________________________ _________________
Please print or stamp | Signature | Date

Address: ____
(City) (State) (Zip code)

Degree: ______________________________ Telephone: ______________________________

(12/5/07)