SHORT TERM DISABILITY BENEFITS CLAIM FORM

Eligibility: Supplemental Short-Term Disability Benefits will begin on the sixtieth (60th) day of a non-occupational disability and continue through the twenty-sixth (26th) week. This benefit is available for the participant only. Maximum allowance is 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, your physician, and your employer must complete this form.
- Once you begin to receive any statutory benefits, submit the check stub for these benefits with your completed claim form.

Part A. CLAIMANT'S INFORMATION – COMPLETE ALL INFORMATION:

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: _____ E-mail address: _____

Part B. 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: _____

PART C. EMPLOYERS STATEMENT:

Employer's Name: _____ Policy Number:_____

Employer's Address: _____ Telephone number:_____

Employee's Name: _____ Employee's ID Number: _____

Employee's Address:_____

Was the employee provided with the Statement of Rights (Form DB271S) ❑ Yes ❑ No If "Yes", date: _____

Is Employee a ❑ Member ❑ Owner ❑ Partner ❑ Spouse Employee's Occupation:_____

Date of Employment:_____ ❑ Full time worker ❑ Part time worker Social Security Number:_____

Normal work week: (check boxes to show usual days worked) ❑ Sun. ❑ Mon. ❑ Tue. ❑ Wed. ❑ Thur. ❑ Fri. ❑ Sat.

Date Employee Last Worked:_____ Date Employee Wages Ceased:_____

Has Employee returned to work? ❑ Yes ❑ No If "Yes" date:_____

Has employment terminated? ❑ Yes ❑ No If "Yes," why?_____

Are wages being continued during disability? ❑ Yes ❑ No If "yes," does employer request reimbursement? ❑ Yes ❑ No

Was employee on job when disability occurred? ❑ Yes ❑ No

Has claim been filed for Workers' Compensation? ❑ Yes ❑ No

Name of Workers' Compensation carrier:_____

Is Employee member of a union that provides for payment of weekly cash benefits? ❑ Yes ❑ No

If "yes," give name, address and telephone number of union: _____

_____

Does employee contribute to cost of this insurance? ❑ Yes ❑ No

If "yes," is employee contribution the maximum permitted by law? ❑ Yes ❑ No Other: $_____ per_____

Earnings 8 weeks prior to disability, include weekly value of board, lodging and tips:

	Week Ending (MM/DD/YY)	No. Days Worked	Gross Amount
1			
2			
3			
4			
5			
6			
7			
8			

Employer tax ID: _____ Signed: _____

Title: _____ Date: _____