



HOUSE STAFF BENEFITS PLAN

10-27 46TH AVENUE, SUITE 300-2, LONG ISLAND CITY, NY 11101

Phone: (212)-356-8180

Fax: (212)-356 – 8181

benefits@cirseiu.org

www.cirseiu.org

SHORT TERM DISABILITY BENEFITS CLAIM FORM

Eligibility: Supplemental Short-Term Disability Benefits will begin on the eighth (8th) 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 System	_____	_____
Ear	_____	_____	Abdomen	_____	_____	Skin	_____	_____
Teeth	_____	_____	Ano-rectal	_____	_____	Lymph nodes	_____	_____
Neck	_____	_____	Varicosities	_____	_____	Genio-urinary	_____	_____
Lungs	_____	_____	Musculo-skeletal	_____	_____	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: _____

Address: _____ Please print or stamp _____ Signature _____ Date _____

_____ (City) _____ (State) _____ (Zip code)

Degree: _____ Telephone: _____

PART C. EMPLOYER'S 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: _____