

**DISABILITY CLAIM FORM**  
**TO BE COMPLETED BY EMPLOYER OR ORGANIZATION**

**Part A**

Name of Insured (Please Print): \_\_\_\_\_ Soc. Sec. No \_\_\_\_\_

Address of Insured: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Group Number: \_\_\_\_\_ Effective Date of Insurance: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation	Date Last Worked	Date Returned To Work	Did Disability Occur Due to Occupational Causes?
Was Employment Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No	When	For What Reason	Insured's Average Base Wage Immediately Preceding Disability? \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

Signed By _____	Date _____	Percent of Premium Paid By Employee _____
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Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Part B**

**TO BE COMPLETED BY EMPLOYEE**

Complete Only If Claim Caused By Injury  
 Date of Injury \_\_\_\_\_ Where Did The Accident Happen? \_\_\_\_\_  
 How Did It Happen? \_\_\_\_\_

Has This Claim Been Filed With Any Other Insurance Carrier?  Yes  No  
 If So, Please List Name, Address, Phone Number, and Name Of Policy Holder \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**Part C**

**ATTENDING PHYSICIAN'S STATEMENT**

1. ICD9 Diagnosis Code Primary _____ Secondary _____	Diagnosis and Concurrent Conditions _____
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2. Is Condition Due to Injury or Sickness Arising Out of Patients Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Date Symptoms First Appeared Or Accident Happened _____
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4. Has Patient Ever Had Same Or Similar Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, When and Describe _____
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5. If Condition is Related to Pregnancy, Please Include Estimated Delivery Date \_\_\_\_\_

6. Patient Was Continuously Totally Disabled and Unable to Work From _____ Thru _____	7. Patient was Partially Disabled From _____ Thru _____
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8. If Still Disabled, Date Patient Should Be Able to Return to Work _____	9. Dates of Treatment _____
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10. Was Your Patient Hospital Confined?  Yes  No Dates of Confinement: \_\_\_\_\_

11. Was Surgery Performed?  Yes  No Date \_\_\_\_\_  
 Procedure \_\_\_\_\_  
 Please Print:  
 Physicians Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_ Zip \_\_\_\_\_

12. Was This Patient Referred to  Referred By  Another Dr? If so:  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_