

SHORT TERM DISABILITY BENEFITS

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

**THIS FORM IS FOR SHORT-TERM DISABILITY BENEFITS ONLY.
TO AVOID DELAY OR RETURN, PLEASE FOLLOW THESE INSTRUCTIONS.**

- To the Claimant:
- A. Complete and sign the Claimant section.
 - B. Have the Attending Physician complete and sign the Attending Physician section.
 - C. Return the fully completed form to your Employer/Administrator who will submit the form to the claim office.

TO BE COMPLETED BY THE CLAIMANT

Name of Employee (Last Name)	(First Name)	(M.I.)	Date of Birth	Social Security No.	Gender
					<input type="checkbox"/> M <input type="checkbox"/> F

Address (Street)	(City)	(State)	(Zip Code)	Telephone No.
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Date of Accident or Beginning of Illness	First Date you were Unable to Work	Date you plan to Return to Work
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Was your Disability caused by any of the following, **answer all questions:** Accident Yes No Auto Accident Yes No

Work Related Injury/Illness Yes No If work related has a Workers Compensation claim been filed Yes No
(If Workers Compensation has been denied, submit a copy of the denial with this claim form)

Describe, in your own words, the condition(s) affecting you (if accident, describe circumstances and location of accident).

Please list any Hospitals, Clinics, or Physicians that treated you for your Illness, or Injury.		
Name	Complete Address	Treatment Period

Please give your Occupation and describe your Job duties in detail. What percentage of your job requires physical labor?

Please list All benefits you are receiving or eligible to receive under any other Group Insurance, Government Plan or Automobile Mandatory No-Fault coverage. Include Name, Address, and Telephone number of other Carrier.

Benefit	Address	Gross Weekly Amount	Date Began	Paid thru Date
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THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Employee: _____ Date Signed: _____

Authorization to Release Information

To all physicians and other health care professionals, and all hospitals and other health care institutions: You are authorized to provide BenefitSourceInc. or it's representatives information concerning health care advice, treatment or supplies provided to the Patient (including those relating to mental illness or substance abuse, HIV infection, AIDS, or AIDS related complex). This information will be used for the purpose of evaluating and administering claims for benefits. This authorization is valid for the term of coverage for the policy or contract under which a claim has been submitted. I know that I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. This release shall be considered valid for one year from the date signed.

Signature of Employee: _____ Date Signed: _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

(Please complete all questions to avoid delay in processing of the claim)

Diagnosis and concurrent conditions, including ICD-9 or DSM-III code.

Is this condition due to pregnancy? Yes No If "yes" please provide the information below, if applicable.

Approximate date pregnancy commenced

Estimated date of confinement

Date and type of delivery

 Normal
 C-Section

Complications, if any

Is the condition due to injury or illness caused by the patient's employment? Yes No

Date symptoms first appeared or accident happened.

Date patient first consulted you for this condition.

Dates of services – include date of next appointment (if previous form submitted to this payor, you need show only dates since last report)

Has the patient ever had same or similar condition? Yes No If "yes" when and describe.

Patient still under your care for this condition?

 Yes NoHas the patient been hospital confined? Yes No If "yes" confined from: _____ thru: _____

Name and Address of hospital: _____

Nature of Surgical procedure, if any: _____

 Inpatient Outpatient Date performed: _____

Patient was continuously totally disabled – (unable to work).

If still disabled, date patient should be able to return to work.

From: _____ Thru: _____

Reason(s) why this condition prevents patient's return to full-time employment.

Date

Physician's Name (please print)

Signature

Degree

Tax Identification Number

Telephone Number

Street Address

City or Town

State or Province

Zip/Postal Code

TO BE COMPLETED BY THE EMPLOYER

PLEASE CHECK THE APPROPRIATE BOXES REGARDING THE INSURED'S EMPLOYMENT STATUS.

 Exempt Non-Exempt Salaried Hourly Full-time Part-time

Basic Earnings per week

Date of last change in Earnings

Date Hired

Effective date of Insurance

Last Date Worked

Number of Hours

Date Returned to Work

Salary Continuance Paid thru date

Name of Employer

Division

Address (Street)

(City)

(State)

(Zip Code)

Telephone Number

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THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Authorized Representative: _____ Date Signed: _____