bac

SHORT-TERM DISABILITY CLAIM FORM

INSTRUCTIONS: THIS FORM IS TO BE FILED AS SOON AS IT APPEARS THAT YOU WILL QUALIFY FOR DISABILITY BENEFITS. UPON COMPLETION, RETURN FORM TO THE GROUP POLICYHOLDER.

A. STATEMENT OF EMPLOYEE: (TO BE FILLED OUT BY EMPLOYEE – PLEASE ANSWER ALL QUESTIONS FULLY)

1. YOUR NAME (LAST, FIRST, M.): | DATE OF BIRTH (MM/DD/YYYY): | SOCIAL SECURITY NUMBER:

2. HOME ADDRESS: | CITY: | STATE: | ZIP CODE:

3. YOUR TELEPHONE NUMBER: | SEX: ◯ MALE ◯ FEMALE | IS THIS A NEW ADDRESS?: ◯ NO ◯ YES

4. YOUR OCCUPATION: | DID DISABILITY RESULT FROM EMPLOYMENT? ◯ YES ◯ NO

5. HAVE YOU BEEN CONTINUOUSLY DISABLED SINCE YOU BECAME UNABLE TO WORK?:
◯ **YES, APPROXIMATELY WHEN DO YOU FEEL YOU WILL BE ABLE TO RESUME WORK?**
◯ **NO, WHEN DID YOU AGAIN BECOME ABLE TO WORK?** **DATE:** **HOUR:** ◯ **A.M.** ◯ **P.M.**

6. REASON FOR DISABILITY:
◯ **ACCIDENT – DESCRIBE INCLUDING DATE AND PLACE:**
◯ **SICKNESS – WHEN DID SYMPTOMS FIRST APPEAR?**

7. HAVE YOU BEEN HOSPITAL CONFINED?: ◯ **NO** ◯ **YES, FROM WHEN:** **TO:** | NAME OF HOSPITAL:

HOSPITAL ADDRESS: | CITY: | STATE: | ZIP CODE:

8. DO YOU HAVE DISABILITY INSURANCE WITH OTHER COMPANIES?
◯ **NO** ◯ **YES, GIVE NAMES OF COMPANIES AND POLICY NUMBERS:**

9. YOUR DOCTORS DURING THE PAST YEAR: | SICKNESS OR INJURY: | DATE CONSULTED:

10. **THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**
I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, INSURANCE COMPANY, EMPLOYER, OR ORGANIZATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, DISABILITY, OR BENEFITS PAYABLE.
A PHOTO-STAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
THIS AUTHORIZATION SHALL EXTEND TO MY SPOUSE AND DEPENDENTS.

X _____ _____
EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

B. STATEMENT OF GROUP POLICYHOLDER: (TO BE COMPLETED BY GROUP POLICY HOLDER)

TO BE COMPLETED BY GROUP POLICY HOLDER

EMPLOYEE'S NAME: | I.D. NUMBER: | UNIT OR DIVISION NUMBER:

INSURANCE CLASS: | EFF. DATE OF INSURANCE: | EFF. DATE OF LAST CHANGE:

WAS CLAIMANT IN YOUR EMPLOY WHEN DISABILITY BEGAN? ◯ **YES** ◯ **NO** | EMPLOYEE'S START DATE: | DATE LAST WORKED:

WAS INSURANCE IN FORCE WHEN DISABILITY BEGAN? ◯ **YES** ◯ **NO** | IS EMPLOYEE'S INSURANCE STILL IN FORCE? ◯ **YES** ◯ **NO, GIVE DATE OF TERMINATION:**

TYPE OF BENEFIT: ◯ **WEEKLY INCOME** ◯ **MONTHLY INCOME** ◯ **WAIVER OF LIFE PREMIUM** | HAS EMPLOYEE RETURNED TO WORK? ◯ **NO** ◯ **YES, GIVE DATE OF RETURN:**

EMPLOYEE'S SALARY: ◯ **WEEKLY, $:** ◯ **MONTHLY, $:** | AMOUNT OF BENEFIT CLAIMED: **$** | ACCOUNT NUMBER:

GROUP POLICY HOLDER: | TELEPHONE NUMBER:

GROUP POLICY HOLDER'S SIGNATURE: X | TITLE: | DATE SIGNED (MM/DD/YYYY):

PLEASE, HAVE YOUR PHYSICIAN COMPLETE ALL INFORMATION ON BACK OF PAGE

C. ATTENDING PHYSICIAN'S STATEMENT: (THIS SECTION TO BE COMPLETED BY PHYSICIAN – PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN

HISTORY:

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?

DATE PATIENT CEASED WORK BECAUSE OF DISABILITY?

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

◯ **NO** ◯ **YES, STATE WHEN AND DESCRIBE:**

NAMES OF ANY ADDITIONAL TREATING PHYSICIANS:

ADDRESS OF ADDITIONAL PHYSICIANS:

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

◯ **YES** ◯ **NO** ◯ **UNKNOWN**

DIAGNOSIS:

DIAGNOSIS (INCLUDING ANY COMPLICATIONS):

DATE OF LAST EXAMINATION:

SUBJECTIVE SYMPTOMS:

OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS):

DATES AND NATURE OF TREATMENT:

DATE OF FIRST TREATMENT:

DATE OF LAST TREATMENT:

FREQUENCY:

◯ **WEEKLY** ◯ **MONTHLY** ◯ **OTHER:**

NATURE OF TREATMENT (INCLUDING SURGERY AND MEDICATIONS PRESCRIBED, IF ANY):

PROGRESS:

HAS PATIENT...

◯ **RECOVERED?** ◯ **IMPROVED?** ◯ **UNCHANGED?** ◯ **RETROGRESSED?**

IS PATIENT...

◯ **AMBULATORY?** ◯ **HOUSE CONFINED?** ◯ **BED CONFINED?** ◯ **HOSPITAL CONFINED – IF YES, ANSWER THE NEXT THREE...**

NAME OF HOSPITAL PATIENT HAS BEEN CONFINED AT:

CONFINED FROM:

CONFINED THROUGH:

HOSPITAL'S MAILING ADDRESS:

CITY:

STATE:

ZIP CODE:

CARDIAC (IF APPLICABLE):

FUNCTIONAL CAPACITY (AMERICAN HEART ASSOCIATION):

CLASS/LIMITATION: ◯ **1/NO LIMITATION** ◯ **2/SLIGHT** ◯ **3/MARKED** ◯ **4/COMPLETE**

BLOOD PRESSURE (LAST VISIT):

PROGNOSIS:

	PATIENT'S JOB:		ANY OTHER WORK:	
IS PATIENT NOW TOTALLY DISABLED?	◯ **YES**	◯ **NO**	◯ **YES**	◯ **NO**
WHAT DUTIES OF PATIENT'S JOB IS HE/SHE INCAPABLE OF PERFORMING:				
DO YOU EXPECT A FUNDAMENTAL MARKED CHANGE IN THE FUTURE?	◯ **YES**	◯ **NO**	◯ **YES**	◯ **NO**
IF YES, WHEN WILL/OR DID PATIENT RECOVER SUFFICIENTLY TO PERFORM DUTIES?	◯ ____ / ____ / 20____		◯ ____ / ____ / 20____	
IF NO, PLEASE EXPLAIN:	◯ **1 MO.**	◯ **3-6 MO.**	◯ **1 MO.**	◯ **3-6 MO.**
OTHER REMARKS?:	◯ **1-3 MO.**	◯ **NEVER**	◯ **1-3 MO.**	◯ **NEVER**

PHYSICIAN'S INFORMATION:

PHYSICIAN'S NAME:

SPECIALTY:

TELEPHONE NUMBER:

PHYSICIAN'S MAILING ADDRESS:

CITY:

STATE:

ZIP CODE:

PYSICIAN'S AUTHORIZATION:

X _____

PROVIDERS'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DEGREE/TITLE:** **DATE SIGNED** (MM/DD/YYYY):