

WEEKLY DISABILITY INCOME CLAIM FORM

A. THIS SECTION TO BE COMPLETED BY THE EMPLOYEE:

Employee: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ SSN: _____

Employer: _____ Home Phone: _____

Employer's Address: _____ Work Phone: _____

Is condition due to an injury or accident? Yes No

Is condition due to illness or injury arising out of your employment? Yes No

If yes, please explain how the condition occurred: _____

Please describe illness or injury: _____

Date of onset: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Signature of Employee: _____ Date: _____

B. THIS SECTION TO BE COMPLETED BY THE EMPLOYER:

1. Was the claimant covered under this plan on the date of onset of illness or injury? Yes No
2. Was the illness or injury due to occupational causes? Yes No
3. Do you have information to indicate that there is other group coverage? Yes No
4. What percent of premium for this disability benefit does the employer pay? _____ %
5. First date employed: _____ Earnings: \$ _____ per _____.
6. Employee status on date of illness or injury: _____ hours per week
7. First full day unable to work: _____
8. Signature of employer representative: _____

Title: _____ Date: _____

C. TO BE COMPLETED BY ATTENDING PHYSICIAN OF THE EMPLOYEE LISTED ABOVE:

1. Date patient first sought medical advice for illness or injury: _____
 2. Extent of patient's disability: _____
 3. Patient will be continuously totally disabled (and unable to work) from: (Date) _____ through (Date) _____.
 4. Anticipated length of disability: _____ Anticipated date patient will return to work: _____
 5. Has patient been treated for this condition within the past 12 months? Yes No
 6. Next scheduled office visit for patient: _____
 7. Signature of attending physician: _____
- Date: _____
- Address: _____ Phone Number: _____