APPLICATION FOR DISABILITY BENEFITS

PART A - TO BE COMPLETED BY EMPLOYER

1. Policy Number _____
2. Employer (Company) Name _____ Employer Tax ID # _____
3. Employer Address _____
   Street Address
   _____
   City State Zip Phone
4. Employee's Name _____ Social Security # _____
5. Employee's date of hire _____ Employee's effective date of disability ins. _____
   (month/day/year) (month/day/year)
6. Last date employee work _____ Reason for stopping work _____
   (month/day/year)
7. Occupation at time of disability (attach copy of complete job description or describe job here including all important duties).
   _____
   _____
8. Basic monthly earnings _____ Work schedule _____
   days per week hours per day
9. Will (or has) employee file(d) for Unemployment Compensation or for Disability Benefits provided by any Employer - Employee, Labor Management, or Union Welfare Plan? ☐ Yes ☐ No
   If "YES", please identify _____
10. Is this employee eligible for Salary Continuation? ☐ Yes Amount $_____ per _____ Duration
    ☐ No
11. Is this employee eligible for Worker's Compensation? ☐ Yes Amount $_____ per _____ Carrier
    ☐ No
12. Is this employee eligible for Pension Disability or Disability Retirement? ☐ Yes Amount $_____ per _____
    ☐ No
13. Has employee returned to work on a full-time basis yet? ☐ Yes Date _____ (month/day/year)
    ☐ No
14. Has employee returned to work on a part-time basis yet? ☐ Yes Date _____ (month/day/year)
    ☐ No
15. Has employee worked elsewhere after date of disability? ☐ Yes Where? _____
    ☐ No
16. Does the employer withhold Social Security Tax (FICA) from the employees regular wages? ☐ Yes ☐ No
17. Does the employer pay all premiums for the disability coverage? ☐ Yes ☐ No
    If "NO", what percentage of disability premium does employer pay? _____%
18. Is employer considered a ☐ private or ☐ public enterprise?

Completed By (signature) _____ Date _____

Title _____ Phone _____

PART B - TO BE COMPLETED BY DISABLED EMPLOYEE

1. My full name is _____ Social Security # _____
2. My home address is _____
Street Address
_____
City State Zip Phone
3. Personal Data: Date of Birth _____ Sex _____ Height _____ Weight _____
(month/day/year)
Martial Status _____ Spouse's Date of Birth _____ Spouse Employed? ☐ Yes ☐ No
(month/day/year)

No. of Children _____ First names and birthdates _____
_____
4. Occupation _____ List the important duties of your occupation at time of disability.
_____
5. I have been unable to work because of this disability since _____.
(month/day/year)
6. I returned to work on a part-time basis on _____. I returned to work on a full-time basis on _____.
(month/day/year) (month/day/year)
7. I was first treated for this illness or injury on _____. I was first treated for this illness or injury by:
(month/day/year)
Dr's Name _____ Address _____
Dr's Name _____ Address _____
8. I first notice symptoms of this illness or injury on _____. Describe the first symptoms of your illness
(month/day/year)
or describe how and where your accident occurred. _____
_____
9. Is your accident or illness related to your occupation? ☐ Yes ☐ No
If "Yes", please explain_____
_____
10. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
If "Yes", when? _____
Who treated you? _____Address_____
Hosp. Name _____ Address_____
11. Describe all income you are receiving or might be eligible to receive as a result of your present disability: (Examples: Social Security; Workers' Comp.; State Disability; Pension Disability; Disability Retirement; Early Retirement; Association Disability or Retirement; Other Group Disability; etc.) Note: You should apply for all benefits you might be eligible for as soon as possible. PLEASE ATTACH COPY OF THE SCHEDULE OF INSURANCE, COPY OF THE CLAIM PAYMENT RECORDS, OR COPY OF THE AWARD NOTICE OF THESE BENEFITS.

Describe Source	Amount of Income	Date Income Began	Date Ended

Signature of Employee _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

PART A TO BE COMPLETED BY PATIENT (INSURED)

Full Name of Patient (please print)	Date of Birth	Policy No.
Present Address Street City State Zip Social Security #		
If Group Insurance, Give Name of Policyholder *(i.e., Employer, Union or Association through whom insured)*	Insured's Occupation	
	Patient's Phone #	

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize any physician, dentist, medical practitioner, hospital, clinic, pharmacy or any other provider of health care, any insurance company, government agency, consumer reporting agency, or employer to disclose to the plan's claim processor, or its authorized medical, underwriting and claims representatives all information and records relating to a diagnosis, treatment, medical history, physical and mental condition and evaluation or any other information relating to me or my dependent children. Such records and information may be used by the plan's claim processor, now or in the future in connection with the underwriting of my application for insurance, the reinstatement, renewal or continuation of any policy issued, and any claims on any policy issued. I understand any information obtained will not be released by the plan's claim processor, to any person or organization except its re-insurers, other persons or other organizations performing business or legal services in connection with my application or policy, or as may be required by law, or as I may further authorize. A photocopy of this authorization shall be as valid as the original. For the purpose of collecting information in connection with a claim for benefits this authorization remains valid for the term of coverage if the claim is for a health insurance benefit, or the duration of the claim if the claim is not for a health insurance benefit. For all other purposes, this authorization remains valid for thirty (30) months from this date. I have a right to receive a copy of this authorization upon request.

Signature of Employee: _____ Date: _____

PART B TO BE COMPLETED BY ATTENDING PHYSICIAN

1. HISTORY
   - (a) When did symptoms first appear or accident happen? Month _____ Day _____Year_____
   - (b) Date patient ceased work because of disability? Month _____ Day _____Year_____
   - (c) Has patient ever had same or similar condition? Yes ☐ No ☐ If "Yes", state when and describe
     _____
   - (d) Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐ Unknown ☐
   - (e) Names and addresses of other treating physicians:
     _____
     _____

2. PRESENT CONDITION
   - (a) Subjective symptoms_____
   - (b) Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings) _____
     _____
   - (c) Date of last examination. . . . . Month _____ Day _____Year_____

3. DIAGNOSIS (including any complications)

4. DATES OF TREATMENT
   - (a) Date of first visit. . . . . Month _____ Day _____Year_____
   - (b) Date of last visit . . . . . Month _____ Day _____Year_____
   - (c) Frequency. . . . . Weekly ☐ Monthly ☐ Other ☐ Specify _____

5. NATURE OF TREATMENT (including name and date of surgery, medications prescribed, and therapy, if any)

6. PROGRESS
   - (a) Has patient. . . . . Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed ☐
   - (b) Is patient . . . . . Ambulatory ☐ House confined ☐ Bed Confined ☐ Hospital confined ☐
   - (c) Has patient been hospital confined . . . . . Yes ☐ No ☐
     If "Yes" give name and address of hospital
     _____
     _____ Confined from _____ through _____

7. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)
   - ☐ Class 1 - no limitation of functional capacity; capable of heavy work* no restrictions. (0-10%)
   - ☐ Class 2 - medium manual activity*. (15-30%)
   - ☐ Class 3 - slight limitation of functional capacity; capable of light work*. (35-55%)
   - ☐ Class 4 - moderate limitation of functional capacity; capable of clerical/administrative sedentary*) activity. (60-70%)
   - ☐ Class 5 - severe limitation of function capacity; incapable of minimum (sedentary*) activity. (75-100%)

   Remarks:

8. CARDIAC (if applicable)

(a) Functional capacity (American Heart Assoc.) Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation) ☐

(b) Is Angina Pectoris Present? Yes ☐ No ☐

(c) Are signs of congestive failure present? Yes ☐ No ☐

(d) Blood pressure (last visit) _____ (systolic/diastolic)

(e) Please list cardio active drugs given: _____

9. PULMONARY (if applicable)

(a) Degree of limitation (check one)
☐ Can perform ordinary physical activity comfortably.
☐ Can perform ordinary physical activity but experiences discomfort and is restricted.
☐ Cannot perform ordinary physical activity.

(b) X-ray findings: _____

(c) Results of pulmonary testing: FVC_____ FEV _____ MEFR _____ 1.0

10. MENTAL/NERVOUS IMPAIRMENT (if applicable)

(a) What stress and problems in interpersonal relations has claimant had on job?
☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).
Remarks:

(b) Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes ☐ No ☐

11. PROGNOSIS

(a) Is patient NOW totally disabled and unable to perform patient's job . . . . . Yes ☐ No ☐
If "Yes", when do you expect patient will recover sufficiently to perform patient's job?
1 month ☐ 1-3 months ☐ 3-6 months ☐ Never ☐
When did disability begin? _____

(b) Is patient NOW totally disabled and unable to perform any other work? . . . . . Yes ☐ No ☐
If "Yes", when do you expect patient will recover sufficiently to perform another occupation considering education and experience? 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never ☐

12. REHABILITATION

	Patient's Job	Any Other Work
(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)	Yes ☐ No ☐	Yes ☐ No ☐
(b) When could trial employment commence?	_____ (month/day/year) Full time ☐ Part time ☐	_____ (month/day/year) Full time ☐ Part time ☐
(c) Would vocational counseling and/or retraining by recommended	Yes ☐ No ☐	

REMARKS:

I authorize the hospital in which confinement took place to furnish the plan's claim processor, full information and disclose all facts concerning the physical condition of the above named patient. A photostat of this authorization shall be considered as effective and valid as the original.

Name of Attending Physician (print) _____ Degree _____ Telephone _____

Street Address _____ City _____ ST _____ Zip Code _____

Signature X _____ Date _____