Administered by:
Group Administrators, Ltd.
915 National Parkway, Suite F • Schaumburg, IL 60173 • (847) 519-1880 • www.groupadministrators.com

Disability Claim

STATEMENT OF EMPLOYER

Employee's Name | I.D. No. | Unit or Div. No.

Benefit Plan | Date of Employment | Eff. Date of Plan | Eff. Date of Last Change

% | $

Percentage of premium paid by Employer | Salary continuance or sick pay | Paid from | Thru

Was coverage in force when disability began? .... ☐ Yes ☐ No Date Employee last worked ________

Is Employee's coverage still in force?.......... ☐ Yes ☐ No If no, give date of termination ________

Has Employee returned to work? .... ☐ Yes ☐ No If yes, give date returned ________

Type and Amount of Benefit Claimed: ☐ **Long Term Disability** $ ________ ☐ **Short Term Disability** $ ________ ☐ **Life Coverage During Disability** $ ________

Employee's Salary: Monthly: $ ________ Weekly: $ ________ Eff. Date of Salary: ________

Employer | Plan No.

Date | By (Signature) | Title | Telephone #

INSTRUCTIONS TO EMPLOYEE

(1) This form is to be filed as soon as it appears that you will qualify for disability benefits..

(2) Complete the **Statement Of Employee** and the **Authorization For Release Of Information** below.

(3) Have your physician complete the Attending Physician's Statement on the reverse side.

(4) Return Form to your Employer.

STATEMENT OF EMPLOYEE

Your Name | Telephone Number

Your occupation | Date of birth | Social Security No.

When did you become wholly unable to work? Date ________ Hour ________ A.M. ________ P.M.

Have you been continuously disabled since you became unable to work? .... ☐ **Yes** ☐ **No**

If yes, approximately when do you feel you will be able to resume work? ________

If no, when did you again become able to work? Date ________ Hour ________ A.M. ________ P.M.

Is disability due to ☐ **accident** or ☐ **sickness.** (If accident, describe, including date and place. If sickness, when did symptoms first appear?)

____

____

Have you been hospital confined? ☐ **Yes** ☐ **No.** If yes, when? From ________ To ________

Name of hospital ________
Address

Did disability result from employment? ☐ **Yes** ☐ **No.** If yes, amount of Workers' Compensation benefit: $ ________

Do you have disability insurance with other companies? ☐ **Yes** ☐ **No.** If yes, give names of companies and policy numbers:

____

Name and address of your doctors during the past year ▼	Sickness or Injury ▼	Date Consulted ▼

These statements are true and complete to the best of my knowledge ________ (Signature of Employee) ________ (Date)

AUTHORIZATION FOR RELEASE OF INFORMATION

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Group Administrators, Ltd., or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

Date ________ Signature of Employee ________ Is this a new address? ☐ **Yes** ☐ **No**

Address of Employee ________
Street | City | State | Zip Code

DISABILITY CLAIM

ATTENDING PHYSICIAN'S STATEMENT

1. HISTORY

(a) When did symptoms first appear or accident happen? .... Mo. ________ Day ________ Year ________

(b) Date patient ceased work because of disability? .... Mo. ________ 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. DIAGNOSIS

(a) Diagnosis (including any complications)

____

(b) Subjective symptoms

____

(c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings

____

3. DATES OF TREATMENT

(a) Date of first visit .... Mo. ________ Day ________ Year ________

(b) Date of last visit .... Mo. ________ Day ________ Year ________

(c) Frequency .... ☐ Weekly ☐ Monthly ☐ Other (Specify) ________

4. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)

____

____

5. 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 ________

6. CARDIAC (If Applicable)

(a) Functional capacity (American Heart Association) ☐ **Class 1** (No limitation) ☐ **Class 2** (Slight limitation) ☐ **Class 3** (Marked limitation) ☐ **Class 4** (Complete limitation)

(b) Blood Pressure (last visit) .... ________ / ________

SYSTOLIC DIASTOLIC

7. PROGNOSIS

	PATIENT'S JOB		ANY OTHER WORK	
(a) Is patient now totally disabled?	☐ Yes	☐ No	☐ Yes	☐ No

(b) What duties of patient's job is he/she incapable of performing?

____

	PATIENT'S JOB		ANY OTHER WORK	
(c) Do you expect a fundamental or marked change in the future?	☐ Yes	☐ No	☐ Yes	☐ No
(d) If yes, when will/or did patient recover sufficiently to perform duties?	☐ ______		☐ ______	
	☐ 1 mo.	☐ 3-6 mo.	☐ 1 mo.	☐ 3-6 mo.
Remarks ________________________	☐ 1-3 mo.	☐ Never	☐ 1-3 mo.	☐ Never

8. REHABILITATION

(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.) .... ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? .... ☐ Yes ☐ No

(c) When could trial employment commence? ....

PATIENT'S JOB: ______ Mo. Day Yr. ☐ Full-time ☐ Part-time

ANY OTHER WORK: ______ Mo. Day Yr. ☐ Full-time ☐ Part-time

(d) Would vocational counseling and/or retraining be recommended? ☐ Yes ☐ No

PRINT Physician's Name ________ Degree ________ Specialty ________ Telephone ________

Street Address ________ City ________ State or Province ________ Zip Code ________

Date ________________ Signature ________________________________

Tax Identification Number