

Disability Claim

Administered by: **Group Administrators, Ltd.**20 N. Martingale Rd, Suite 100 • Schaumburg, IL 60173 • (855) 978-2331 • www.groupadministrators.com

Employee's Name    Date of Employment   Eff Date of Plan   Eff. Date of Plan								
Security Sec	Employee's Name		I.D	). No.	Unit or Div. No.	Unit or Div. No.		
Start continuous of premium paid by Employer   Salary continuance or sick pay   Ped from   Thru	Benefit Plan	Date of Emp	loyment	Eff. Date of Plan	Eff. D	ate of Last Change		
Ves		•						
Employee's coverage still in force?						Thru		
as Employee returned to work?   Long Term Disability   Short Term Disability   Life Coverage During Dis	=	· ·		• •	-			
yos and mount				, 0	•			
## Samployee's Salary:    Monthly: \$   Weekly: \$   Eff. Date of Salary:		rk?		, , 5		rage During Disability		
to By (Signature)  Title  Tolephone ≠  NSTRUCTIONS TO EMPLOYEE  1) This form is to be filled as soon as it appears that you will qualify for disability benefits. 2) Complete the Statement Of Employee and the Authorization For Release Of (4) Return Form to your Employer.  STATEMENT OF EMPLOYEE  Our Name  Telephone Number  Telephone Nu				more remi bisability	<del>.</del>	rage During Disability		
ates By (Signature)  NSTRUCTIONS TO EMPLOYEE  1) This form is to be filed as soon as it appears that you will qualify for disability benefits. 2) Conclude the Statement Of Employee and the Authorization For Release Of Information heldow.  STATEMENT OF EMPLOYEE  STATEMENT OF EMPLOYEE  Our Name  Telephone Will Return Form to your Employer.  Telephone Number  A.M.  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  If yes, approximately when do you feel you will be able to resume work?  If obsibility due to ☐ accident or ☐ sickness. (If accident, describe, including date and place. If sickness, when did symptoms first appear?)  ave you been hospital confined? ☐ Yes ☐ No. If yes, amount of Workers' Compensation benefit: \$  and address of your doctors during the past year ▼	mployee's Salary:	Monthly: \$	Weekly: \$		Eff. Date of Salary:			
NSTRUCTIONS TO EMPLOYEE    This form is to be filed as soon as it appears that you will qualify for disability benefits   Complete the Statement Of Employee and the Authorization For Release Of Information below.   (4) Return Form to your Employer.	mployer				Plan No.			
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 or reversal side.  (4) Return Form to your Employer.  Telephone Number  Telephone Number  Telephone Number  Date of birth Social Security No. Henry A.M.  All.  ave you been continuously disabled since you became unable to work?  If no, when did you again become able to work? Date  If no, when did you again become able to work? Date  If no, when did you again become able to work? Date  All.  disability due to □ accident or □ sickness. (If accident, describe, including date and place. If sickness, when did symptoms first appear?)  ave you been hospital confined? □ Yes □ No. If yes, when? From □ To □  ame of hospital  are of hospital yesulf from employment? □ Yes □ No. If yes, amount of Workers' Compensation benefit:  \$ o you have disability insurance with other companies? □ Yes □ No. If yes, give names of companies and policy numbers:  ame and address of your doctors during the past year ▼ Sickness or Injury ▼ Date Consulted ▼  Sickness or Injury ▼ Date Consulted ▼  No offer 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 in gedriding my medical history, symptoms, treatment, examination results or degrades. A photocopy of this authorization shall be considered a diff for the duration of the dailing, but not to exceed one year from the date signed. Turnderstand I have the right to receive a copy of this authorization shall be considered a list.  Signature of Employee □ Is this a new address? □ Yes	ate	By (Signature)	Tit	le	Telephon	e#		
reverse side.  (4) Return Form to your Employer.   TATEMENT OF EMPLOYEE  Dur Name  Telephone Number  A.M.    Yes   Yes   Yes   Yes    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.    If no. when did you again become able to work? Date   Hour   A.M.    Idisability due to   accident or   sickness. (if accident, describe, including date and place. If sickness, when did symptoms first appear?)  To    ame of hospital   Address    Idisability result from employment?   Yes   No. If yes, amount of Workers' Compensation benefit: \$  o you have disability insurance with other companies?   Yes   No. If yes, give names of companies and policy numbers:  The patent of Employee   Temployee   Temployee   Temployee   Temployee   Temployee   Is this a new address?   Yes   Yes   No. If yes are the reflect or release to Group Administrators, Ltd., or its representative, any it agarding my medical history, symptoms, treatment, examination results or degnoss. A photocopy of this authorization shall be considered address or a solid as the origin to receive a copy of this authorization shall be considered and as effective accopy of this authorization shall be considered and as effective accopy of this authorization shall be considered and is the first to receive a copy of this authorization shall be considered and is stored. In understand I have the right to receive a copy of this authorization shall be considered and in the patent of the first of the duration of the claim, but not to exceed one year from the date signed								
Complete the Statement of Employee and the Authorization For Release Of Information below.	This form is to be filed a	s soon as it appears that you will qualify fo	r disability benefits		plete the Attending Phys	ician's Statement on the		
our occupation  Our occupation  Date of birth  Social Security No.  When did you become wholly unable to work?  Date  Hour  A.M.  Yes  If yos, approximately disabled since you became unable to work?  If no, when did you again do you gel you will ke?  If no, when did you again do you gel you will ke?  If no, when did you again do you gel you will ke?  If no accident or sickness. (If accident, describe, including date and place. If sickness, when did symptoms first appear?)  It was you been hospital confined? Yes No. If yes, when? From  To  It was you been hospital confined? Yes No. If yes, amount of Workers' Compensation benefit:  It was you have disability insurance with other companies? Yes No. If yes, give names of companies and policy numbers:  It was you have disability insurance with other companies?  Yes No. If yes, give names of companies and policy numbers:  It was your doctors during the past year ▼ Sickness or Injury ▼ Date Consulted ▼  WITHORIZATION 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 in sperdering my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the originature of Employee  Is this a new address? Yes		nt Of Employee and the Authorization Fo	r Release Of		oloyer.			
our occupation    Date of birth   Social Security No.		EMPLOYEE	-					
Date of birth Social Security No.  Then did you become wholly unable to work?  Date  Hour  A.M.  Yes  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.  disability due to ☐ accident or ☐ sickness. (If accident, describe, including date and place. If sickness, when did symptoms first appear?)  are you been hospital confined? ☐ Yes ☐ No. If yes, when? From  To  are of hospital  Address  id disability result from employment? ☐ Yes ☐ No. If yes, amount of Workers' Compensation benefit:  To  To  To  Date Consulted ▼  Sickness or Injury ▼  Date Consulted T  Date Consulted								
Then did you become wholly unable to work? Date	our Name				Te	ephone Number		
ave you been continuously disabled since you became unable to work?	our occupation			Date of birth	So	cial Security 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	hen did you become wholly	unable to work? Date		Hour	A.M	P.		
If no, when did you again become able to work? Date Hour A.M. disability due to □ accident or □ sickness. (If accident, describe, including date and place. If sickness, when did symptoms first appear?)  ave you been hospital confined? □ Yes □ No. If yes, when? From To  ame of hospital  Address  id disability result from employment? □ Yes □ No. If yes, amount of Workers' Compensation benefit: \$  o you have disability insurance with other companies? □ Yes □ No. If yes, give names of companies and policy numbers:  ame and address of your doctors during the past year ▼ Sickness or Injury ▼ Date Consulted ▼  AUTHORIZATION FOR RELEASE OF INFORMATION  To □  Date Consulted ▼  (Signature of Employee) (Date)  **UTHORIZATION FOR RELEASE OF INFORMATION  To □  To □  Address  Sickness or Injury ▼ Date Consulted ▼  (Signature of Employee) (Date)  **UTHORIZATION FOR RELEASE OF INFORMATION  To □  To □  To □  Address  Sickness or Injury ▼ Date Consulted ▼  (Signature of Employee) (Date)  **UTHORIZATION FOR RELEASE OF INFORMATION  To □  To	ave you been continuously d	lisabled since you became unable to work?				Yes N		
disability due to	If yes, approximately wh	nen do you feel you will be able to resume v	vork?					
ame of hospital  Address  id disability result from employment?			pe, including date and pl			P.		
Address id disability result from employment?	ave you been hospital confin	ed? Yes No. If yes, when? Fr	om		То			
id disability result from employment?	ame of hospital			• • •				
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 in regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the origulation 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 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 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 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 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 shall be considered valid for the duration of the claim, but not to exceed one year from the date signed.				ation benefit: \$				
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egarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original purpose and the 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 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 shall be considered as effective and valid as the original purpose. I understand I have the right to receive a copy of this authorization shall be considered as effective and valid as the original purpose. I understand I have the right to receive a copy of this authorization shall be considered as effective and valid as the original purpose. I understand I have the right to receive a copy of 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 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 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 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 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 shall be considered valid for the duration of the claim, but not to exceed one year from the date signed.								
ddress of Employee	egarding my medical history, uthorization shall be consider	symptoms, treatment, examination results red valid for the duration of the claim, but n	s or diagnosis. A photo ot to exceed one year from	copy of this authorization shall be com the date signed. I understand I h	onsidered as effective ar ave the right to receive a	d valid as the original. T copy of this authorization.		
Street City State Zip Code								

## **DISABILITY CLAIM**

1. HSTORY  (a) When did symptoms first appear or accident happear?  (b) Date patient cossed work because of disability?  (c) Has prilated evariated same or similar condition?  (d) Is condition due to injury or sickness arising and of patients employment?  (e) Names and addressees of dinds theating physicians.  2. DIAGNOS IS  (a) Diagnose (including any complications)  (b) Subjective symptoms  (c) Objective Inditings (including outset X reys, EKGs, Laboratory Date and any circual findings  3. DATES OF TREATMENT  (a) Date of first viet.  (b) Date of list viet.  (c) Frequency  (d) Frequency  4. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)  5. PROGRESS  (a) His patient  (b) Each of list viet.  (c) Frequency  (d) Has patient been hospital confined?  (e) Has patient been hospital confined?  (e) Has patient been hospital confined?  (e) Has patient been hospital confined?  (f) Has patient been hospital confined?  (g) Has patient been hospital confined?  (g) Has patient been hospital confined been confined by (g) Has patient been hospital confined?  (g) Loss 3 (Nafwed Imitation)  (g) Each 4 (Complete limitation)  (g) Bood Pressure (sat viet)  (g) De you expect a fundemental or marked change in the future?  (g) De you expect a fundemental or marked change in the future?  (g) De you expect a fundemental or marked change in the future?  (g) De you expect a fundemental or marked change in the future?  (g) De you expect a fundemental or marked change in the future?  (g) Hasp when while did patient revolves sufficiently be performed to a fundemental or marked change in the future?  (g) Hasp when while did patient revolves sufficiently be performed to a fundemental or marked change in the future?  (g) When could trial employment commerce?  (g) When could trial employment commerce?  (g) Was pounded trial employment commerce?  (h) Diagratic to the future of the patient probabili			ATTENDING PHYSICIAN	'S S	ГАТЕМЕ	NT		
Dise patient cased dox bisusus of disability?   Mo   Day   Year	1.	HIS	TORY					
(c) Has patient even had some or similar condition?		(a)	When did symptoms first appear or accident happen?	Mo.		Day		Year
(c) Has patient even had some or similar condition?		(b)	Date patient ceased work because of disability?	Mo.		Day		Year
(e) Names and addresses of other treating physicians		(c)			☐ No			
(e) Names and addresses of other treating physicians								
2. DIAGNOSIS (a) Elegrosis (reducting 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		(d)	Is condition due to injury or sickness arising out of patient's employment?	Yes	☐ No	Unknown		
2. DIAGNOSIS (a) Elegrosis (reducting 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		(e)	Names and addresses of other treating physicians					
(a) Dagnosis (including any complications)  (b) Subjective symptoms  (c) Objective infindings (including current X-ays, EKG's, Laboratory Data and any clinical findings  3. DATES OF TREATMENT  (a) Date of first visit		. ,	<b>3.</b> ,					
(b) Subjective symptoms (c) Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings  3. DATES OF TREATMENT (a) Date of first visit	2.	DIA	GNOSIS					
(c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings  3. DATES OF TREATMENT  (a) Date of first viait		(a)	Diagnosis (including any complications)					
(c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings  3. DATES OF TREATMENT  (a) Date of first viait								
3. DATES OF TREATMENT  (a) Date of first visit		(b)	Subjective symptoms					
3. DATES OF TREATMENT  (a) Date of first visit		(c)	Objective findings (including current V rays, EVC's Laboratory Data and any clinical find	inge				
(a) Date of first visit		(0)	Objective illumings (including current A-rays, ENG's, Laboratory Data and any clinical lind	iiiys				
(a) Date of first visit	•	D 4 :	TEC OF TREATMENT					
(b) Date of last visit	3.					_		
Co.   Frequency		(a)		•				Year
NATURE OF TREATMENT (including Surgery and medications prescribed, if any)		(b)	Date of last visit	Mo.		Day		Year
5. PROGRESS (a) Has patient   Recovered   Improved   House confined   Bed confined   House confined   House confined   House confined   House confined   House confined   House confined   Hospital Confined		` '			eekly [	☐ Monthly ☐	Other (Specify)	
Recovered	4.	NA.	TURE OF TREATMENT (Including Surgery and medications prescribed, if an	ıy)				
Recovered								
Recovered								
(b) Is patient   Ambulatory   House confined   Hospital Confined	5.	PR	_					
Georgian		1. 1		لمما	□Unch	anged	□ Retrogressed	
(c) Has patient been hospital confined?		(D)						
6. CARDIAC (If Applicable) (a) Functional capacity   Class 1 (No limitation)   Class 2 (Slight limitation)   Class 4 (Complete limitation)   Class 4 (Complete limitation)   Class 4 (Complete limitation)   Class 5 (Marked limitation)   Class 5 (Marked limitation)   Class 6 (Class 4 (Complete limitation)   Class 6 (Class 6 (Complete limitation)   Class 7 (Class 7 (Class 7 7		(c)	<u> </u>		ital			
6. CARDIAC (If Applicable) (a) Functional capacity   Class 1 (No limitation)   Class 2 (Slight limitation)   Class 4 (Complete		(-)				nm	through	
(a) Functional capacity   Class 1 (No limitation)   Class 3 (Complete limitation)   Class 4 (Complete limitation)   Class 5 (No Class 4 (Complete limitation)   Class 5 (No Class 4 (Complete limitation)   Class 6 (Complete limitation)   Class 6 (Complete limitation)   Class 6 (Complete limitation)   Class 7 (Complete limitation)   Class 7 (Complete limitation)   Class 8 (Complete limitation)   Class 9 (Complete limitation)   Complete limitation   Class 9 (Complete limitation)   Complete limitation   Complete	6.	CA	RDIAC (If Applicable)	_		····		
(b) Blood Pressure (last visit)					☐ Clas	s 2 (Slight limitation)		
7. PROGNOSIS (a) Is patient now totally disabled? (b) What duties of patient's job is he/she incanable of performing?  (c) Do you expect a fundamental or marked change in the future?			(American Heart Association) Class 3 (Marked limitation)		, $\square$ Clas	s 4 (Complete limitat	tion)	
7. PROGNOSIS (a) Is patient now totally disabled? (b) What duties of patient's job is he/she incanable of performing?  (c) Do you expect a fundamental or marked change in the future? (d) If yes, when will/or did patient recover sufficiently to perform duties? (d) If yes, when will/or did patient recover sufficiently to perform duties? (e) Do you expect a fundamental or marked change in the future? (d) If yes, when will/or did patient recover sufficiently to perform duties? (e) In mo.   3-6 mo.   1 mo.   3-6 mo.   1 mo.   3-6 mo.   1 mo.   3-6 mo.   Never  8. REHABILITATION (a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)   Yes   No   No   No   No   No   No   No   N		(b)		IC	J DIAC	TOLIC		
(a) Is patient now totally disabled?  (b) What duties of patient's job is he/she incapable of performing?  (c) Do you expect a fundamental or marked change in the future?	7.	PR					ANY OTHER	WORK
(c) Do you expect a fundamental or marked change in the future?		(a)	Is patient now totally disabled?					
City   State or Province   City   State or Province   City   City   State or Province   City   Cit	(b)	Wha	t duties of patient's job is he/she incapable of performing?					
City   State or Province   City   State or Province   City   City   State or Province   City   Cit								
Remarks		(c)	Do you expect a fundamental or marked change in the future?	[	Yes	☐ No	☐ Yes	☐ No
Remarks		(d)	If yes, when will/or did patient recover sufficiently to perform duties?		<u> </u>			
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?  PATIENT'S JOB  ANY OTHER WORK  (c) When could trial employment commence?  Mo. Day Yr. Part-time  Mo. Day Yr. Part-time  (d) Would vocational counseling and/or retraining be recommended? Yes No  PRINT  Physician's Name  Degree  Specialty  Telephone  Zip Code					☐ 1 mo.	☐ 3-6 mo.	☐ 1 mo.	☐ 3-6 mo.
(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)		Rem	narks	[	1-3 mo.	□ Never	☐ 1-3 mo.	□ Never
(b) Can present job be modified to allow for handling with impairment?	8.	REI	HABILITATION					
Cc) When could trial employment commence?		(a)		•	•	, ,		
(c) When could trial employment commence?		(b)	Can present job be modified to allow for handling with impairment?					
Mo. Day Yr. 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		(-)	When you like the make an order or a constant of the constant or a const					
(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		(c)				Me		
PRINT     Physician's Name     Degree     Specialty     Telephone       Street Address     City     State or Province     Zip Code		(4)	·	ш.	unt tillio		о. <i>Б</i> ау 1111	
Street Address City State or Province Zip Code		(u)	Note to construct coursesing and/or retraining be reconfinitely.					
Street Address City State or Province Zip Code								
	PRIN	T	Physician's Name Degree			Specialty	Telephone	
Data Cianahura	Stree	t Addres	ss City			State or Province	Z	ip Code
Date Signature	Da	ıte	Signature					