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

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