



DISABILITY CLAIM FORM

SEND
CLAIMS
DIRECTLY
TO:

MedBen
P.O. Box 1099 • Newark, Ohio 43058-1099
(740) 522-8425 • Toll-Free (800) 423-3151

Statement of Employer

Employee's Name _____ Social Security No. _____ 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 _____ through _____

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** **Short Term** **Life Coverage**
 Disability \$ _____ Disability \$ _____ During Disability \$ _____

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

Employer _____ Group/Account No. _____

Date _____ By _____ Signature _____ Title _____ Telephone # (_____) _____
Area Code

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 # (_____) _____

Your Occupation _____ Date of Birth _____ Social Security # _____

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 for this disability? 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 health practitioner or facility; any insurance company or health care plan; or any state or federal agency providing health care benefits; and any employer to release to MedBen Mutual Life Insurance Co. or MedBen Administrators, Inc., or their legal representatives any information regarding my medical history, symptoms, treatment, examination results, prognosis, or diagnosis. In addition, I authorize any provider of health care services, claims administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, me. 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 _____

Address of Employee _____
Street City State Zip Code

Is this a new address? Yes No

DISABILITY CLAIM FORM

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, EKGs, Laboratory Data and any clinical findings)

3. Dates of Treatment

- (a) Date of first visit Mo. Day Year
(b) Date patient ceased work because of disability 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? Regressed?
(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 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

- (a) Is patient now totally disabled? Patient's Job Any Other Work
(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? Yes No Yes No
(d) If "Yes", when will/or did patient recover sufficiently to perform duties? 1 mo. 1-3 mo. 3-6 mo. Never

8. Rehabilitation

- (a) Is patient a suitable candidate for further rehabilitation services? 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 Any Other Work
(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
Date Signature Tax Identification Number