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# Disability Claim Form

## 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 Disability \$** \_\_\_\_\_  **Short Term Disability \$** \_\_\_\_\_  **Life Coverage During Disability \$** \_\_\_\_\_

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

Employer \_\_\_\_\_ Group/Account No. \_\_\_\_\_

Date \_\_\_\_\_ By \_\_\_\_\_ Title \_\_\_\_\_ Telephone # ( \_\_\_\_\_ ) \_\_\_\_\_

Signature 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 \_\_\_\_\_

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)  
*(American Heart Assoc. classes)*  Class 3 (Marked limitation)  Class 4 (Complete limitation)
- (b) Blood Pressure (last visit) ..... Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

**7. Prognosis**

- |  |   |   |
|--|---|---|
|  | <b>Patient's Job</b>  | <b>Any Other Work</b>   |
| (a) Is patient now totally disabled? .....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| (b) What duties of patient's job is he/she <u>incapable</u> of performing? _____ |   |   |
| (c) Do you expect a fundamental or marked change in the future? .....            | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| (d) If "Yes", when will/or did patient recover sufficiently to perform duties?   | <input type="checkbox"/> _____<br><input type="checkbox"/> 1 mo. <input type="checkbox"/> 1-3 mo. | <input type="checkbox"/> _____<br><input type="checkbox"/> 1 mo. <input type="checkbox"/> 1-3 mo. |
| Remarks _____  | <input type="checkbox"/> 3-6 mo. <input type="checkbox"/> Never                                   | <input type="checkbox"/> 3-6 mo. <input type="checkbox"/> Never                                   |

**8. Rehabilitation**

- (a) Is patient a suitable candidate for further rehabilitation services? .....  Yes  No  
 (i.e., cardiopulmonary program, speech therapy, etc.)
  - (b) Can present job be modified to allow for handling with impairment? .....  Yes  No
- |   |                                    |                                    |
|---|------------------------------------|------------------------------------|
|   | <b>Patient's Job</b>               | <b>Any Other Work</b>              |
| (c) When could trial employment commence? ..... | <input type="checkbox"/> Full-time | <input type="checkbox"/> Full-time |
|   | <input type="checkbox"/> Part-time | <input type="checkbox"/> 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	
Date _____	Signature _____			Tax Identification Number _____