

DISABILITY CLAIM FORM

SEND
CLAIMS
DIRECTLY
TO:

MedBen
P.O. Box 1009 • Newark, Ohio 43058-1009
(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 _____ Title _____ Telephone No. (_____) _____
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** below and the **Authorization for Release of Information** on the following page.
- (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 No. (_____) _____
Area Code

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 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 to Disclose Protected Health Information

Name of Patient/Employee _____ Social Security No. _____

Address _____
No. Street City State Zip

I authorize the physician who signs the Attending Physician's Statement, and all persons and entities affiliated with, part of, or employed by the physician's organized health care arrangement (the "Provider"), to disclose and send the completed Disability Claim Form/Attending Physician's Statement to:

Medical Benefits Mutual Life Insurance Company ("MedBen")
1975 Tamarack Road
P.O. Box 1009
Newark, Ohio 43058-1009
(740) 522-8425 / (800) 423-3151

Further, I authorize the Provider to respond to questions from MedBen and/or its medical consultants related to the health information in the Attending Physician's Statement and the medical condition, history, symptoms, treatment, examination results, prognosis and diagnosis that are related to my claim for disability benefits.

This disclosure is made at my request.

This authorization will be valid for the duration of my claims for disability benefits under the Disability Plan, but not to exceed one year from the date signed.

I understand that I may revoke this authorization at any time by submitting a written revocation to the Provider, except that a revocation will not be effective to the extent that the Provider has already taken action in reliance on this authorization.

I understand that I can obtain a copy of this authorization from the Provider and/or MedBen if I can request one in writing.

Medical treatment is not conditioned on the execution of this authorization. However, no claim for disability benefits under the Disability Plan will be considered unless the Attending Physician's Statement is submitted to MedBen and no claim for disability benefits will be paid if MedBen determines that it does not have sufficient information to determine whether disability benefits are payable.

I understand that the Provider cannot limit or control the subsequent use, reproduction, or dissemination of the information disclosed pursuant to this authorization.

A photocopy of this authorization is as valid as the original.

Date _____ Signature _____

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 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
Date Signature Tax Identification Number